

**My Family Healthcare, LLC** Requested Provider: \_\_\_\_\_ Approved By/Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First MI Name you prefer to be addressed by

Sex:  Male  Female Birthdate: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Preferred Contact Method: (Phone / Mail / Secure Email)

Address: \_\_\_\_\_  
Mailing Address City State Zip

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph. Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Responsible Party/Guarantor

Patient's relation to guarantor: \_\_\_\_\_

Guarantor's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Insurance Information

Insurance Company: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

### Employment Status

Employment Status: ( Employed / Unemployed / Self Employed / Retired / Student )

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have advanced directives? DNR: Circle One Yes No Power of Attorney? Circle One Medical / Legal

Who may we thank for referring you to our office? \_\_\_\_\_

If you have a provider currently, reason for the change? \_\_\_\_\_

**Please Note:** Please have your insurance cards and photo ID available for our records. We will file your visit with your insurance and your co-payment, deductible, or co-insurance is expected at the time you arrive for your appointment. If you are unable to pay your co-payment, deductible, or co-insurance at the time you arrive for your appointment, you may be asked to reschedule your appointment. If you are scheduled with a My Family Healthcare, LLC provider that is not listed as your PCP, you will be asked to reschedule until your PCP can be verified as changed. Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT INFORMATION SHEET

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

### SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day: \_\_\_\_\_

Alcohol: Currently Past Never Drinks/day: \_\_\_\_\_

**List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.**

Medications

OTC and vitamins


### PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

- |                                   |                     |                             |                         |
|-----------------------------------|---------------------|-----------------------------|-------------------------|
| ADHD                              | COPD                | High Cholesterol            | Peptic Ulcer            |
| Alcoholism                        | Dementia            | HIV                         | Psoriasis               |
| Allergies, Seasonal               | Depression          | Hepatitis                   | Pulmonary Embolism (PE) |
| Anemia                            | Diabetes: 1 or 2    | Irritable Bowel Syndrome    | Rheumatoid Arthritis    |
| Anxiety                           | Diverticulitis      | Kidney Stones               | Sciatica                |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot)    | Kidney Disease              | Seizure Disorder        |
| Arthritis                         | Eczema              | Lupus                       | Sleep Apnea             |
| Asthma                            | Emphysema           | Liver Disease               | Stroke                  |
| Bipolar                           | Gallstones          | Macular Degeneration        | Thyroid Disorder        |
| Bladder problems/Incontinence     | GERD (Acid Reflux)  | Migraines                   | Ulcerative Colitis      |
| Bleeding problems                 | Glaucoma            | Nosebleeds                  |                         |
| Cancer: _____                     | Heart Disease       | Neuropathy                  |                         |
| Carpal Tunnel                     | Heart Attack (MI)   | Osteopenia/Osteoporosis     |                         |
| Headaches                         | Hiatal Hernia       | Parkinson's Disease         |                         |
| Crohn's Disease                   | High Blood Pressure | Peripheral Vascular Disease |                         |

Last Menstrual Period	Yes/No	Normal
	Date: _____	Abnormal
Colonoscopy	Yes/No	Normal
	Date: _____	Abnormal
Mammogram	Yes/No	Normal
	Date: _____	Abnormal
Dxa (Bone Density)	Yes/No	Normal
	Date: _____	Abnormal

**Other medical problems not listed above:**

**Surgical History:** Please list all prior surgeries and approximate dates performed.

**FAMILY HISTORY:**

**FATHER:** Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other: \_\_\_\_\_

**MOTHER:** Living: Age \_\_\_\_\_ Deceased: Age: \_\_\_\_\_

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other: \_\_\_\_\_

**Siblings:** \_\_\_\_\_

**List other medical providers you see on a regular basis** (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

# My Family Healthcare, LLC

1708 Delivery Lane Durant, OK 74701  
Phone (580) 924-5622 Fax (580) 745-5060

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, My Family Healthcare originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.**

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that My Family Healthcare reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that My Family Healthcare is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

# Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS)

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I request the following restrictions to the use and/or disclosure of my health information: \_\_\_\_\_

You \_\_\_\_ may \_\_\_\_ may not leave (appointment reminders, medical information) on my message service or machine.

You \_\_\_\_ may \_\_\_\_ may not fax information to me. My fax number is: \_\_\_\_\_

You \_\_\_\_ may \_\_\_\_ may not contact me by E-mail. My E-mail address is:

\_\_\_\_\_ @ \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Notice Effective

\_\_\_\_\_ accepts \_\_\_\_\_ denies

\_\_\_\_\_ accepts conditionally the restrictions imposed on release of information as stated above (approved by Privacy Officer).

\_\_\_\_\_  
My Family Healthcare Representative

\_\_\_\_\_  
Date

## Medical Home Agreement

**This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.**

### As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with **ongoing, quality and safe** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed **medically** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed **medically** necessary by your PCP.

### As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your **PCP**, to meet **all** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report **any** changes related to your health, treatments, medications, etc.  
This includes use of **all medications** - prescription, over-the-counter, herbal and street drugs.  
This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us **before** going to the Emergency Room, unless it is life threatening.
5. Notify us **after** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including **follow-up** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call **before** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

**Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date



**My Family Healthcare**  
**Medical Marijuana Policy**

Due to the number of medical marijuana cards being issued in recent months, the providers at My Family Healthcare have implemented a policy for medical marijuana card holders.

Your provider's top priority is to provide you with the best medical care possible for both acute and chronic conditions. In order to do that, it is imperative that they know all medications that you are currently taking and that includes medical marijuana. There are medications they may prescribe that are contraindicated while using medical marijuana and the usage of marijuana is contraindicated for people with certain medical conditions. The provider's want to give you the safest care possible and knowing if you use marijuana is essential to do so. Therefore, we are asking that you kindly inform us within 30 days of receiving your medical card. If you are a current card holder, please inform your nurse and provider today. Thank you for your cooperation.

**Social Media Policy**

The providers' and staff at My Family Healthcare take the protection of your health information very seriously. Unfortunately, it has become commonplace for social media and email accounts to be hacked. Due to this ever-increasing risk, as well as following the guidelines of the HIPPA Privacy Policy, we have implemented a social media policy.

If you are needing to speak to a nurse or provider regarding any health-related issues or questions, we ask that you not contact them through social media. That applies to messages through sites such as Facebook, Facebook Messenger, Instagram, or personal email. This is for your personal protection as well as ours. You may contact us by calling the office at (580) 924-5622 and scheduling an appointment or leaving a message for us to call you back or you may contact us through the patient portal. If you do not have a portal account and would like to set one up, please ask one of our office staff to help get you started.

By signing this, you acknowledge that you have received notice of our policies and that you agree to comply.

On behalf of Dr. Brian S. Lee, Mallory Earthman, APRN-CNP, Brooke Decker-Walters, APRN-CNP, and Jennifer Nelson, APRN-CNP we appreciate your understanding.

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Signature

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Date

**No show/ Late Cancellation Policy**  
**Effective January 3, 2023**

In order to provide the best care to all of our patients, My Family Healthcare is implementing the following policy:

Please give us at least 24 hour notice if you are unable to keep your appointment.

Appointments cancelled with less than 24 hours notice will incur a \$25 charge applied to your account.

No Show appointments will incur a \$50 charge applied to your account.

All charges for late cancellation or No Show must be paid prior to scheduling a subsequent appointment.

Any patient having 3 (three) No Show appointments in one calendar year will be subject to dismissal from My Family Healthcare.

By signing below, you acknowledge receipt and understanding of this policy.

If you have any questions, please ask to speak with our Office Manager, Shannon Stovall

Thank you for your cooperation.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Birth