Adult Patient Registration 18YRS and Older

Date_____

Last Name _____ First Name_____ Initial _____

Date of Birth _____ Gender: ☐Female ☐Male SSN: _____ Marital Status_____

Address _____ City _____ State _____ Zip _____

Phone _____ Email_____

Preferred contact: ☐ Phone ☐ Text ☐ Email Preferred Language:_____

☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ Hispanic/Latino Other _____

Employer _____ Occupation_____

Pharmacy _____ Pharmacy Location_____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group #_____

Policy Holder Name _____ DOB:_____

Relationship to Patient _____ SSN _____

Secondary Insurance _____ ID# _____ Group # _____

Policy Holder Name _____ DOB: _____

Relationship to Patient _____ SSN_____

Emergency Contact

Name_____ Phone#_____

Relationship to Patient:_____

Information Release

Agape Family Health has permission to speak concerning my medical care and results with:

☐ Only release information to me personally ☐ Other_____

☐ Leave on voicemail ☐ Text ☐ Email

Agape Family Health has permission to send appointment reminders via ☐ Text ☐ Email

Financial Policy

Agape Family Health, LLC. will file your insurance claims for you, we do request a copy of your current insurance card and valid photo ID to ensure accurate billing. Insurance benefit verification will be performed and recorded in the patient chart before each visit. We do not accept all insurances, it is your responsibility to confirm directly with your insurance company that we participate with them. If you do not have insurance or if your insurance does not cover the services rendered from our clinic, payment is your responsibility. If your insurance company/plan requires a referral, co-pay, coinsurance, or deductible it is your responsibility to have it with you at the time of service. Failure to do so may result in having to reschedule your appointment.

–Medicaid Patients: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require a valid photo ID, which will be scanned into your chart. Lack of this information may result in having to reschedule your appointment.

–Minors: The parent/guardian accompanying the minor at the time of service or the guarantor of the insurance policy to whom the minor has coverage under is responsible for payment.

-We will request copay and or coinsurance payment at the time of service as our contracts require with insurance companies.

–You will receive at least two billing statements after your visit at our clinic. If payment has not been made in full or acceptable payment arrangements have not been made by the time the patient portion of the statement reaches the 91st day, the account balance will be sent to our professional credit bureau, Rapid Recovery, LLC. for collection. The credit bureau will send you notification that a payment is due, the letter will arrive at your last known address.You must respond to this letter to avoid damage to your credit record. Calls may also be initiated by Rapid Recovery, LLC., if a response is not received in the time allotted in the letter.Once the letter of collection has been sent, any payment on this balance must be paid directly to Rapid Recovery, LLC.. If you do not respond to the letter/calls your credit record will be adversely affected.

** I understand and agree that if I or the guarantor of the insurance policy covering dependent/dependents fails to pay for services for which I am responsible, after such default and upon referral to Rapid Recovery, LLC. by Agape Family Health, LLC., I will be responsible for all costs of collecting monies owed, including court costs, and collection agency fees.

–**Appointment Cancellations**- Appointments must be canceled/rescheduled 24 hours prior to the scheduled appointment time. In the result that this kind of situation becomes habitual (more than two appointments) Agape Family Health, LLC. reserves the right to terminate the patient/provider relationship. You will be notified by letter at your last known address.

– **No Showing for appointments**: Agape Family Health, LLC. reserves the right to collect a **$25.00 "No Show" fee** after the second no show for scheduled appointments at our facility **before you will be able to be seen for future care**. In the result that you are unwilling or unable to pay this fee, Agape Family Health, LLC. reserves the right to terminate the patient/provider relationship. You will be notified by letter at your last known address.

– Debit/Credit Card Processing: If a debit/credit card is used to make payment in the office or over the phone, a 3.5% fee of the total amount due will be added to the amount the card is charged for.

–We are disclosing our policy to avoid any misunderstanding in the future.

Patient Name(Printed): _____ Date: _____

Patient/Parent/Guardian/Guarantor Signature: _____
Date: _____

HIPAA POLICY

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

-Obtain medication history from the pharmacy.

-Obtain lab history through various lab portals.

-Obtain payment from third party payers.

-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses of my health information. I have been given the right to read and review your Notice of Privacy Practices from time to time and that I may contact the organization's Privacy Officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are required to agree to my requested restrictions , and if agreed then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Date:_____

Signature:_____ Relationship to patient:_____

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Agape Family Health, LLC and consent to treatment of the NP or PA on duty and whomever they may designate as their assistant, associate, and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks. I acknowledge that failing to cancel an appt without 24 hour notice can result in a 25.00 no show fee.

Patient Name: _____ Date:_____

Signature:_____ Relationship to patient:_____

AGAPE
FAMILY HEALTH

ANNUAL HEALTH HISTORY

Today's Date: _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Preferred Pharmacy Name: _____ **Pharmacy Location:** _____

Do you use Tobacco? ☐ Yes, Currently ☐ No, never ☐ No, I am a former tobacco user
Type of Tobacco Used: ☐ Cigarettes ☐ Chewing ☐ Other _____ How much per day: _____ Years used: _____
Have you ever tried to quit? ☐ Yes ☐ No Year Quit: _____
Are you exposed to passive smoke? ☐ Yes ☐ No

Fall Risk: Have you fallen in the last year? ☐ Yes ☐ No Number of Falls/past year? _____
Do you have problems with walking or balance? ☐ Yes ☐ No

Health Maintenance: Date of last colonoscopy: _____ Date of last Eye Exam: _____ Date of last EKG: _____
Date of last Dental Exam: _____ **Women Only**: Last menstrual period? _____ Date of last pap: _____
Date of last Mammogram: _____ Are you currently pregnant? ☐ Yes ☐ No

Past Medical History: Please mark all that apply.

☐ Allergies	☐ Blood clots	☐ Gallbladder disease	☐ MI (heart attack)
☐ Anemia	☐ Cancer Type:_____	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ CVA (stroke)	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ COPD	☐ High Cholesterol	☐ Peptic Ulcer disease
☐ Arthritis	☐ Coronary Art. disease	☐ High blood pressure	☐ Renal disease
☐ Asthma	☐ Crohn's Disease	☐ Irritable bowel syndrome	☐ Seizure disorder
☐ Atrial Fibrillation	☐ Depression	☐ Liver Disease	☐ Thyroid disease
☐ Benign prostatic hypertrophy	☐ Diabetes	☐ Migraine headaches	☐ Other _____

Past Surgical History:	**Year:**		**Year:**
☐ Angioplasty	_____	☐ Small Bowel Resection	_____
☐ Angio w/stent	_____	☐ Thyroidectomy	_____
☐ Appendectomy	_____	☐ Tonsillectomy	_____
☐ Arthroscopy knee	_____	**FEMALES ONLY:**	
☐ Back surgery	_____	☐ Breast augmentation	_____
☐ CABG	_____	☐ Tubal Ligation	_____
☐ Carpal Tunnel	_____	☐ Breast Biopsy	_____
☐ Cataract extraction	_____	☐ C-Section	_____
☐ Cholecystectomy (gall bladder)	_____	☐ D and C	_____
☐ Colectomy	_____	☐ Hysterectomy	_____
☐ Colostomy	_____	☐ Mastectomy	_____
☐ Gastric Bypass	_____	☐ Myomectomy	_____
☐ Hernia Repair	_____	☐ Breast reduction	_____
☐ Hip replacement	_____	☐ TAH/BSO	_____
☐ Knee replacement	_____	☐ Vaginal Hysterectomy	_____
☐ LASIK	_____	☐ Breastfeeding	_____
☐ Liver biopsy	_____		
☐ ORIF	_____		
☐ Pacemaker	_____		

Family History of (mark all that apply and indicate for Mother, Father, Siblings):

☐ ADD/ADHD _____	☐ CVA (stroke) _____	☐ Learning Disability _____	☐ Other _____
☐ Alcoholism _____	☐ Depression _____	☐ Mental Illness _____	
☐ Allergies _____	☐ Developmental delay _____	☐ Migraines _____	**Age/cause of death of:**
☐ Alzheimer's disease _____	☐ Diabetes _____	☐ Obesity _____	Mother: ☐ n/a _____
☐ Asthma _____	☐ Eczema _____	☐ Osteoarthritis _____	Father: ☐ n/a _____
☐ Blood disease _____	☐ Hearing Deficiency _____	☐ Osteoporosis _____	Siblings: ☐ n/a _____
☐ CAD _____	☐ High Cholesterol _____	☐ Peripheral Vascular disease	
☐ Cancer: Type _____	☐ High blood pressure _____	☐ Renal disease _____	
	☐ Irritable bowel syndrome ___	☐ Seizure disorder _____	

Social History:

Marital Status:
☐ Married ☐ Single
☐ Divorced ☐ Widowed

Alcohol Consumption:
☐ No ☐ Yes ☐ Formerly
Type: _____ Frequency: _____
Amount: _____

Caffeine:
☐ No ☐ Yes Type: _____
Caffeine per day: _____

Living Arrangements:
☐ Alone ☐ Family/Sig.Other
☐ Other ☐ Asst. Living
☐ Daily help needed for self-care
Name of Caregiver: _____

Abuse / Neglect: Adults only
Are you experiencing neglect and/or conflict in your family and/or relationships? ☐ Yes ☐ No
Explain: _____

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory
☐ Bathing
☐ Household Duties
# of Children: _____
Street Drug Use? ☐ Yes ☐ No
Type: _____
Started: _____
Quit: _____

Learning Needs:
Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials?
☐ Yes ☐ No
Please explain: _____

Medications and dosages:	Allergies:	
1.		
2.		
3.		
4.	**Hospitalizations:**	
5.	1.	2.
6.	3.	4.
7.	5.	6.
8.	**Surgeries:**	
Injuries:		

Immunization - When did you last have? (mm/yyyy)

Immunizations: Tetanus ☐ Pneumonia ☐ Flu ☐ TB ☐ Hepatitis B ☐ Other _____

Review of Systems:

General:
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Weight gain/loss
- ☐ Appetite change
- ☐ _____

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn/indigestion
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ _____

Neurologic & Psychiatric:
- ☐ Anxiety/Depression
- ☐ Numbness
- ☐ Weakness
- ☐ Forgetfulness
- ☐ _____

HEENT:
- ☐ Headache
- ☐ Vision changes
- ☐ Ear pain/pressure
- ☐ Nasal congestion
- ☐ Nasal/sinus drainage
- ☐ Sore throat
- ☐ _____

Genitourinary:
- ☐ Frequent urination
- ☐ Urgency
- ☐ Incontinence
- ☐ Painful urination
- ☐ Blood in urine
- ☐ _____

Hematologic/Lymphatic:
- ☐ Abnormal bleeding or bruising
- ☐ Swollen glands
- ☐ _____

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ _____

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Weakness
- ☐ Backache
- ☐ _____

Endocrine:
- ☐ Excessive thirst/hunger
- ☐ Heat/cold intolerance
- ☐ _____

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular/rapid heartbeat
- ☐ Pain or swelling in legs
- ☐ _____

Skin:
- ☐ Rash
- ☐ Itching
- ☐ Changing mole
- ☐ _____

GYN/Breast:
- ☐ Abnormal periods
- ☐ Vaginal discharge
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ _____