Faith Health Care Inc.

Administrative Office
521 Crane Road Somerset, KY 42501
(P) 606-425-5768 (F) 606-425-5769

Science Hill Community Care
5775 N Hwy 27, Ste 6
Science Hill, KY 42553
(P) 606-685-6131 (F) 606-685-6179

Community Care Clinic
126 Franklin Dr
Monticello, KY 42633
(P) 606-396-3534 (F) 606-396-3535

Nancy Family Care
9919 W Hwy 80
Nancy, KY 42544
(P)606-288-0019 (F) 606-288-0020

Patient Information **Date**________________________

Patient Name________________________________ **Birthdate**____________________

Address______________________________ **City**________________ **State**______ **Zip**______

SS# __________________ **Home Phone** ________________ **Cell/Alternate**________________

Emergency Contact____________________ **Relationship**____________ **Phone** ____________

Pharmacy Name/Location ________________________________ **Phone** ____________

Email Address ____

Employer ______________________ **Phone**__________________ **Occupation**______________

If patient is under 18 years of Age:

Father____________________ SS#______________ Birthdate__________ Employer______________

Mother ____________________ SS#______________ Birthdate__________ Employer______________

Are you a Veteran? ☐Yes ☐ No **Do you smoke**? ☐Yes ☐No **Are you disabled?** ☐ **Yes** ☐ **No**

Living Situation : ☐Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐Halfway House/Shelter ☐ Homeless Shelter ☐Transitional ☐ Street ☐ Permanent Supportive Housing ☐Other ________________

Marital Status: ☐Single ☐Married ☐ Widowed ☐ Separated ☐Divorced ☐Domestic Partner

Ethnicity : ☐Hispanic/Latino ☐Non Hispanic/ Latino

Gender: ☐Male ☐ Female ☐Transgender Male ☐Transgender Female ☐ Other ☐Do not wish to disclose

Sexual orientation: ☐Straight ☐ Lesbian/Gay ☐Bisexual ☐Something else ☐ Don't Know ☐Do not wish to disclose

Race : ☐American Indian/Alaskan Native ☐Asian ☐African American ☐Native Hawaiian/Islander ☐White ☐ Other Race

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Self-Employed ☐Student

Migrant Worker? ☐Yes ☐No

Education Level Completed: ☐Less than High school graduate ☐High School Graduate
☐Some College/Associate's Degree ☐Bachelor's degree or higher

What language should your information be provided in? ____

How well do you understand English? ☐Very Well ☐Moderate ☐Very Little ☐ None

Advanced Directives: ☐Yes (Please provide a copy) ☐No

Insurance Information

Is this a Workman's Compensation or auto insurance claim? (If so, please provide this information) ☐Yes ☐No

Do you have Medicaid? ☐Yes ☐ No **Have you applied?** ☐Yes ☐No **Policy Number?**________________________

Do you have health insurance? ☐Yes ☐ No

Name of Insurance____

Person Carrying Insurance __________________________Birthdate________________Relationship________________

I understand that my medical information is confidential. I authorize the exchange of information between CCC and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentially policies are posted in our waiting room and copies are available on request

I hereby authorize treatment by CCC Initials___________

I authorize Community Care Clinic to release my medical records to my insurance carrier, worker's compensation carrier, and/or my attorney. I hereby assign all medical benefits, to which I am entitled, including Medicare, Medicaid, private insurance and any other health plan, to Community Care Clinic. This assignment and authorization will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all medical charges associated with my treatment, whether they are paid by an insurance company or not.

Patient Signature or guardian (If Minor)____Date ______________

Name and relationship (If not patient)____Date_______________

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Health History

Name___________________________________ **DOB** _________________________ **Age**______________

Are you here for a routine exam? ☐ Yes ☐ No

Medical History-Please check if you have had any of the following

___Anemia
___Eye Problems
___Severe Headaches
___Diabetes
___High Blood Pressure
___Heart Disease
___Asthma
___Lung Disease
___Cancer
___Seizure
___Thyroid Problem
___Breast Lump
___Allergies

___ Swollen Legs/ankles
___ Varicose Veins
___ Blood Clots
___ Bleeding Problems
___ Stomach Problems
___ Bowel Problems
___ Kidney problems
___ Liver problems
___ Gallbladder problems
___ Urinary tract infections
___ STD
___ Pelvic Infections

___ Osteoporosis
___ Broken Bones
___ Serious injury/MVA
___ Chemical Dependency
___ Eating Disorder
___ Severe Depression
___ Psychiatric Care
___ Arthritis

WOMEN
Date of last menstrual period
______/_________/________
Pregnancies ________
Births______________

Please describe/explain any of the above problems	**List any HOSPITILIZATIONS or SURGERIES you have had**

List your ALLERGIES

____

Family History (Father, Mother, Brother, Sister, Grandmother, Grandfather)

	Relationship
___ Diabetes	______________
___ Stroke	______________
___ Heart Disease	______________
___ High Blood Pressure	______________
___High Cholesterol	______________
___ Anemia	______________
___ Chronic Lung Disease	______________
___Bleeding Problems	______________

	Relationship
___Breast Cancer	______________
___Colon Cancer	______________
___Ovarian Cancer	______________
___Other Cancer	______________
___Osteoporosis	______________
___Depression	______________
___Anxiety	______________
___Drug/Alcohol Problems	______________

FAMILY HEALTH- List the present age/health status of each of the following family members. If deceased, then list age and cause of death.

FATHER___________________________ MOTHER__________________ SIBLINGS_____________________________

SOCIAL HISTORY

Habits

___ Smoking If yes, how many packs a day______________ How many years?________

___ Smokeless Tobacco use If yes, what type?___________ How many years?_______________

___ Alcohol If yes, how many drinks a day?____________ Drinks per week?_____________

___ Street drug use

___ Seat Belt Use

___ Regular exercise

Personal Profile

Marital Status ___Married ___Single ___ Divorced ___ Widowed

Number of living children ___________ Number of people in household___________

School Completed: ___ High School ___College ___ Graduate Degree

Current/Most recent Job ____

Other

Are you or have you been sexually/physically mistreated? ___________________

Do you want to talk with someone about this? ____________________________

Review of Symptoms- Check all of the symptoms that you are currently experiencing

Constitutional

___Fever

___Chills

___Sweats/Night Sweats

___Fainting

___Weight Change

___Fatigue

___Seizures

___Dizziness

___Sleeping difficulties

Eyes

___Change in Vision

___Burning/itching eyes

___Blurred/double vision

___Redness/Eye pain

Ears, Nose, Mouth, Throat

___Ear pain

___Ringing in ears

___Dry mouth

___Colds

___Sore throat

___Hoarseness

___Difficult swallowing

Respiratory

___Shortness of breath

___Chronic cough

___Bloody sputum

___Wheezing

Cardiovascular

___ Chest Pain

___ Palpitations/heart fluttering

Gastrointestinal

___ Abdominal Pain

___ Heartburn, indigestion

___ Nausea/Vomiting

___ Change in Appetite

___ Change in bowel habits

___ Constipation of diarrhea

___ Dark/Bloody stools

___ Rectal Bleeding

Urinary

___ Painful urination

___ Frequent Urination

___ Urinary Urgency/incontinence

___ Blood in Urine

___ Getting up at night to urinate

Musculoskeletal

___Backache, back pain

___Weakness

___ Joint pain/stiffness

___Muscle Cramps

___Swelling of hands, feet, ankles

___ Leg pain, redness

Skin

___Change in Moles, freckles

___Rash

___ Change in hair growth, loss

___ Nodules

Hematologic/Lymphatic

___Swollen lymph glands

___Easy bruising

___Easy bleeding

Endocrine

___Excessive thirst/urination

__Cold/Heat Intolerance

Breast

___Breast Lumps

___Breast Pain

___Breast Nipple Discharge

Neurological/Emotional

___Memory Change

___Numbness/tingling

___Depression

___Anxiety

___Mood Swings

Women

___Bleeding/pain with intercourse

___Vaginal discharge/odor

___Pelvic Pain

___Vulvar/vaginal itching/burning

___Excessive menstrual bleeding

___Menstrual cramps

___Problems with sexual function

Men

___Pain/lump in testicles

___Difficulty with erections

___Problems with sexual function

Patient Signature:____ **Date:**____________________

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GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: YOU HAVE THE RIGHT, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO ANY SUGGESTED TREATMENT OR PROCEDURE AFTER PLAN HAS BEEN RECOMMENDED. THIS CONSENT FORM IS SIMPLY AN EFFORT TO OBTAIN YOUR PERMISSION TO PERFORM THE EVALUATION NECESSARY TO IDENTIFY APROPRIATE TREATMENT AND/OR PROCEDURE FOR ANY IDENTIFIED CONDITION(S).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating :

- This consent in continuing in nature even after a specific diagnosis has been made and treatment recommended
- You consent to treatment at this office or any other satellite office under common ownership
- This consent will remain fully effective until it is revoked in writing
- You have the right at any time to discontinue services

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider. We encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________

Signature of Patient or Personal Representative Date

______________________________ ______________

Printed Name of Patient or Personal Representative Date

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Controlled Medication Agreement

The contract is binding between myself and my primary care provider at Faith Health Care, INC regarding this policy for being prescribed any controlled substances for the treatment of pain, anxiety, seizures, obesity or other diagnosis of medical necessity.

I understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team
- I will participate in all other types of treatment that I am asked to participate in
- I will keep the medication safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it without first talking to my prescriber/PCP
- I will not call between appointments, at night, or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team of Faith Health Care.
- I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.
- I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
- I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.
- I will sign a release form to let the prescriber/PCP speak to all other doctors or providers that I see.
- I will tell the staff and PCP at Faith Community Care all other medications that I take and make it known right away if I have a prescription for a a new medicine
- I will only use one pharmacy to get my medications
- I will no get any opioid pain medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, amphetamines) without telling a member of the treatment team at Faith Health Care before I fill that prescription. I understand that the only exception to this is if I need pain medication for an emergency at night or on the weekends.
- I will not use illegal drugs such as heroin, cocaine, marijuana or amphetamines. I understand that if I do my treatment may be stopped.
- I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that this will occur at a minimum of each month that I am prescribed any controlled substance while under the care of FHC. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
- I will keep up to date with any bills from the office and tell a member of the treatment team immediately if I lose my insurance or cant pay for treatment anymore.
- I agree to consult with any pain clinic physicians or psychiatrists if so requested by the treatment team of FHC.
- I agree to have KASPER reviewed and discussed at any time deemed necessary by my PCP at FHC for medication care/treatment and continuation of care.

I understand that I may lose my right to treatment in this office if I break any part of this agreement

Patient Signature ______________________________ Date ________________

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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of any and all medical records (Including but not limited to records of any substance abuse, psychiatric/mental health information of HIV/AIDS information) of:

Patient Name (Print) ______________________________ Phone:__________________________

Patient Date of Birth:__________________ Social Security Number _________________________

Please list any physicians or organizations authorized to release the information and any contact information

______________________________________ ___________________________________

______________________________________ ___________________________________

For the following dates of treatment (include specific description of information requested): __________ ALL RECORDS
For the purpose of:
________ Further Medical Care
________ Legal Reasons
________ Self
________Other (Please Specify

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed under this authorization.

This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of Faith Health Care of any legal liability that may arise from the release of the information requested.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has been taken. This authorization will expire automatically one year from the date on which is it signed. Cancellation of this authorization prior to expiration date must be made in writing and sent to the Health Information Management.

Patient Signature: ____ Date:________________________

Guardian/Legal Rep Signature____________________________________Date:________________________

Witness: ____Date:________________________

CURRENT MEDICATIONS LIST

Name ______________________________ **Emergency Contact Name/Number:** ______________________________

Date Last Updated: ________________________ ____________________ ____________________

Prescription Medications:

Name of Medication	**Strength & Frequency**	**Condition Medication taken for**	**Physician who prescribed Medication**	**Notes**

Allergies

Pharmacy/Prescription Drug Plan

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NO SHOW POLICY

Thank you for trusting your medical care to Faith Health Care. When you schedule an appointment with Faith Health Care, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- If you have three (3) No Show or cancellation/reschedule with no 24 hour notice, your provider reserves the right to decline future appointments and care
- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment . If you should experience extenuating circumstances, please contact our office manager to discuss future appointments. Should you need to cancel/reschedule after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left are acceptable.

______________________________________ ____________________

Patient Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN. GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to bay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information to a home health agency that provides care for you or to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing, and conducting or arranging other business activities. We may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready for your visit. We may use or disclose your PHI to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable disease, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation or inmate required uses & disclosures.
Under the law, we must make disclosures to you when required by the Department of Health & Human Services to investigates to determine our compliance with Section 164.500.

Other Permitted and Required Uses and Disclosures:

Will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization at any time, in writing, except to the extent that your provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information,

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to anyone who may be involved in your care

or for the notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

You have the right to receive an accounting of certain disclosures we have made of your protected health information.

We reserve the right to change the terms of this notice and will inform you my mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. Our HIPAA Compliance Officer is Ashley Hickey. She can be contacted at **606-396-3534. We will not retaliate against you for filing a complaint.** This noticed was published and becomes effective on **November 1, 2019.**

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHIO. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at **606-396-3534.**

Print Name: ______________________________

Signature: ______________________________ Date: ____________________

Please list the person(s) that are granted access to your medical records.

Name	Phone	Relationship

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