West Family Care Clinic

Patient Information

Date_____

Last Name_____ **First Name** _____**MI**_____

Address_____ **City** _____**ST**____ **Zip**_____

Cell Phone_____ **Home Phone**_____ **Work**_____

EMAIL ADDRESS: _____

SS#_____ **DOB**_____ **Age**_____ **Sex**_____

Marital Status_____**Employer**_____

Please Circle

Race: American Indian Asian Black White Other

Ethnicity: Non-Hispanic Hispanic Other

Language: English Spanish Chinese Japanese

Spouse Name_____

Spouse DOB_____ **Phone**_____

Emergency Contact:

Name_____ **Phone** _____ **Relation**_____

Do you have an Advanced Directive (Living Will or Power of Attorney)? YES / NO

Responsible Party\ Guarantor

Name_____

Address_____

DOB_____**SS#**_____

Insurance Information_____**ID#**_____

West Family Care Clinic

108 East Drive
Newbern, TN 38059
(731) 627-3553

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize_____ and its physicians, employees, and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to: _____

Purpose of disclosure: _____.

This authorization will expire on: _____
(Date may not exceed one year)

This request and authorization applies to:

_____ All Medical Records

_____ Health Care information relating to the following treatment, condition or dates Of treatment: _____

_____ Specific records to be released (ex. Labs, Imaging Reports, Other):
_____.

If you DO NOT WANT certain portions of your medical records released, please initial beside the information you do not want released.

_____Substance abuse _____Psychological or Psychiatric treatment _____HIV / AIDS / STD

I understand that I have the right to revoke this authoriazation by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice or revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by the federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____
Signature of Patient of Authorized Representative:

_____
Date:

_____
Relationship to Patient:

West Family Care Clinic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO TREAT

I have received a copy of West Family Care Clinic's Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may change at any time. I may obtain a revised copy of the Notice by calling (731) 627-3553 or by requesting one at the following office:

West Family Care Clinic
Attn: Privacy Officer
108 East Drive
Newbern, TN 38059
lbwest@westfamilycareclinic.com
www.westfamilycareclinic.com

Date: _____

Print Name: _____ Signature: _____

As the representative of _____, I acknowledge receipt of the Notice on his or her behalf.

Date: _____

Print Name: _____ Signature: _____

Consent for Medical Treatment

I authorize West Family Care Clinic and personnel to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary:

Date: _____

Print Name: _____ Signature: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

West Family Care Clinic

Date_____ Pharmacy_____

Patient Name_____ M/F DOB_____

Allergies_____

Current Medications

Please list all medications and any over the counter drugs, energy drinks, diet or sleep aids

Medication	Strength\MG	Dosage (how often)	Prescribing doctor

West Family Care Clinic

PERSONAL HEALTH HISTORY

Date: _____

Name: _____ M / F DOB: _____

Reason for visit: _____

Have you been a patient in a hospital overnight recently? When?

_____

Recent ER visit? _____

History of Surgeries _____

Have you ever been diagnosed or treated for the following problems? Check if YES

Abdominal pain	Esophageal Reflux	Skin rash	**Do You: Have You:**	**FAMILY HISTORY**
Allergies	Fainting\Collapse	Stroke	Smoke\ Dip	Depression
Anemia	Fever	Sleep problems	Drink alcohol	Diabetes
Asthma	Hearing loss	Snoring	Energy drinks	Heart disease
Bladder problems	Headaches	Stomach ulcer	OTC meds	Heart attack
Bleeding problems	Heart problems	Swelling legs	Illegal drugs	Blood pressure
Blood clots	Heart attack	Swallowing	Vitamins	Kidney Disease
Blood Pressure	Heart Murmur	Thyroid disorder	Exercise	Obesity
Bronchitis	Heartburn	Tumor/mass	Pacemaker	Stroke
CANCER	Hoarseness	Weight gain	Use Oxygen	Thyroid
Chest Pain	Hernia	Weight loss	Blood transfusion	Anxiety
Cholesterol	Joint pain	Vision problems	Colonoscopy	Alzheimer's
Constipation	Leg cramps		Mammogram	Asthma
Cough	Memory loss	Sinus	Last Pap	Cancer
Colon	Nausea\ Vomiting	Congestion		COPD
Diabetes	Nosebleeds	Sore throat		Cholesterol
Diarrhea	Prostate problems	**Other**		Memory loss
Dizziness/balance	Pain (chronic)			**Other**
Ear pain	Seizures	HIV Positive		
Emphysema	Shortness of breath	Pregnant		