# Client Information Form

## General Information

Client Name: (Last) _____ (First) _____ DOB: _____ Age: ____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Social Security Number: _____ Drivers License: _____

**Please provide a drivers license at the time of your initial visit.

Email: _____

## Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone Number: _____ (ext): _____

## In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

## Financial Policy:

Thank you for selecting Family Clinic of Parsons, LLC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks.

I agree to pay any charges incurred for insufficient funds related to personal checks, minimum fee of $35.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's signature Date

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

# Medical History Information

Name: _____ Age: _____ Age: M F Family Physician: _____

Do you have any allergies to medications or foods? No Yes (please list) _____

Please check all that apply:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes. Age of onset _____
  - o Do you use Insulin? Yes No
- ☐ Glaucoma
- ☐ Psychiatric Illness
- ☐ Drug Abuse
- ☐ Liver Disease _____
- ☐ Heart attack/angina, if so when? _____
- ☐ Constipation
- ☐ Feet swelling
- ☐ Frequent headaches/migraines
- ☐ Lung Disease _____
  - o Tobacco use Yes No type: _____
- ☐ Alcohol Abuse
- ☐ Kidney Disease

Have you ever been diagnosed with anything not listed above? No Yes (please list)

_____

_____

Have you ever had surgery? No Yes (please list)

_____

_____

Do you currently take any medications or vitamins? No Yes (please list med, dose and frequency include dose )

_____

_____

If child-bearing age, what form(s) of contraception do you currently use? _____

Family History (please list any serious illnesses or conditions):

| | Age | Health Status | Disease | Cause of Death | Overweight? |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| Sister(s) | | | | | |

## Nutritional & Behavioral Evaluation

Present Weight: _____ Height: _____ Desired Weight: _____ Weight at 20yrs of age: _____

Weight one year ago: _____ In what time frame would you like to be at your desired weight? _____

What is the main reason for your decision to lose weight? _____

What has been your maximum lifetime weight (non-pregnant) and when? _____

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When did you begin gaining excess weight? (Give reasons, if known)

_____

_____

Previous diets you have followed. Please give dates and results of your weight loss.

_____

_____

What restaurants do you frequent? _____ How often do you eat "fast food?" _____

Foods you dislike? _____ Foods you crave? _____

Any specific time of the day or month do you crave food? _____

Do you drink coffee or tea? Yes No How much daily? _____ Cola ? Yes No How much daily? _____

Do you drink alcohol? Yes No Type? _____ How much? _____

Do you use sugar substitute? Yes No Butter? Yes No Margarine? Yes No

What are your worst food habits? _____

Snack habits? (type) _____ how much? _____ when? _____

When you are in a stressful situation do you tend to eat more? Explain:

_____

_____

Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

**Smoking Habits: (check only one)**

___ You have never smoked tobacco ___ You quit smoking ___ years ago and have not smoked since

___ You smoke less than a pack per day ___ You smoke ~1 pack per day ___ You smoke ~ 1 ½ packs per day

___ You smoke ~2 pack per day ___ You smoke more than 2 packs per day

**Activity Level: (check only one)**

___ Inactive (no regular physical activity) ___ Light activity (no organized physical activity)

___ Moderate activity (occasionally involved in activities) ___ Heavy activity (consistent regular activities)

___ Vigorous activity (at least 60min 4 times per week of physical exercise)

**Behavior Style: (check only one)**

___ You are always calm and easygoing ___ You are usually calm and easygoing

___ You are sometimes calm with frequent impatience ___ You are never calm and have overwhelming ambition

___ You are seldom calm and persistently driving for advancement ___ You are hard-driving and can never relax

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

# Family Clinic of Parsons, LLC
## Patient Authorization Form
## Advance Directives

### Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.

2. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable,

3. I allow fax transmittal of my medical records, if necessary.

4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment,

5. In the event the charges incurred are not paid-in-full when due and collection action is instituted, whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all cost associated with such collection activity including, but not limited to, reasonable collection agency fees, attorney fees, and court costs,

6. I further authorize and request that insurance payments be made directly to the provider.

7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.

8. I agree with all the above with the exception of number.

9. I acknowledge full financial responsibility for services rendered by Family Clinic of Parsons, LLC.

Patient (or Guardian) Signature: _____ Date: _____

Witness_____ Date: _____

**Advanced Directives:**
Do you have a living will or durable power of attorney? ____Yes ____No

If you have a durable power of attorney, please identify; _____

Patient Signature: _____

Witness: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

# Family Clinic of Parsons, LLC

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Family Clinic of Parsons, LLC (from this point on referred to as PRACTICE) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by PRACTICE describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at PRACTICE.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to attention Office Manager at PRACTICE

With this consent, PRACTICE may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PRACTICE may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, PRACTICE may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Clinic of Parsons, LLC may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.