Date___/___/_____ Would you approve if Acts Medical Clinic included you in our prayers? Yes_____ No _____

Patient Name: _____ DOB:_____

Initial Visit Medical History Form (p.1): Please provide the following medical information to the best of your ability:

What problems are you here for today:

_____
_____
_____
_____

List any allergies to medications:

_____
_____
_____
_____

Past Medical History:

1. Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Diabetes	___	___	_____	Stomach or intestinal problems	___	___	_____
Hypertension (high blood pressure)	___	___	_____	Allergy problems/therapy	___	___	_____
Thyroid problems	___	___	_____	Kidney problems	___	___	_____
Heart disease/cholesterol problems	___	___	_____	Neurological problems	___	___	_____
Respiratory problems	___	___	_____	Other medical diagnosis	___	___	_____
Bleeding disorder	___	___	_____				

_____
_____
_____

2.Please list any operations (and dates) you have ever had (including tonsils and adenoids):

_____
_____
_____

3. Please list any current medications (and amounts, time per day):
(Include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, and OTC nasal sprays/cold/sinus/allergy meds)

_____
_____
_____
_____

Social History:	Yes	No
Do you smoke? List how much	___	___
If no, did you smoke previously?	___	___
How often do you drink alcohol?		
What type of alcohol do you prefer?		
What is your occupation?		

Please list details below:

_____
_____
_____
_____
_____

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.
If yes, please indicate which relative(s) have the problem.

	Yes	No	
Heart problems/murmurs	___	___	_____
Allergy	___	___	_____
Diabetes	___	___	_____
Cancer	___	___	_____
Bleeding disorder	___	___	_____
Anesthesia problems	___	___	_____

Reviewed by:_____

Acts Medical Clinic

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We make every effort to inform you f we believe a service may not be covered. However, it is your responsibility to know the coverage limitations of your insurance contract. Since we do contract with several insurance companies, it is impossible for us to know the requirements of each individual policy.

Payment is due at time of service. We accept cash, MasterCard or Visa. Please be aware that your account will be subject to a $25.00 collection fee for balances older than 90 days.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of services rendered, We realize that temporary financial problems do arise; we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

I hereby assign, transfer, and release to Acts Medical Clinic all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice given by the revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

If you have a balance for more than 90 days it is your responsibility to make payment arrangements with us. If you have not made arrangements with us you will have to pay the balance in full before any services are provided.

Patient/Guardian's signature:_____ Date_____

Acts Medical Clinic

1. Dr. Clayton is a board certified Family Physician.
2. He has been a physician for over 20 years.
3. Dr. Clayton does not admit to any hospital, but has great relationships with the hospitals in the area and will be able to track your admission, care and discharge.
4. All payments are due at the time of service.
5. No routine narcotics or nerve pills are prescribed. If any are prescribed, we will not replace if lost, stolen, washed, etc.
6. We do not prescribe routine weight loss medications.
7. We make every effort to treat all our patients with respect and we ask the same of all our Patients. Therefore, any patient who is rude to the staff will be released from this practice.
8. Three missed scheduled appointments will result in release from this practice.
9. There will be a $30.00 fee for each missed Physical Exam appointment as well as a $30 fee for a new patient missed appointment.
10. We work in partnership with our patients, so if we have not called with your appointment or medication it is your responsibility to call and remind us.
11. No refills will be given after hours, and please allow us 72 hours to complete your requested refills.
12. There is no copayment due for a lab review visit. If any other services are provided during that visit you will be responsible for paying a copayment.

Patient Name:_____ Date:_____

HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for _____. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTHCARE INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___ It was emergency treatment
___ *The patient refused to sign*
___ Other (please describe)

___ I could not communicate with the patient
___ *The patient was unable to sign because*
_____

_____

PATIENT INFORMATION

NAME: (FIRST)_____(MI)_____(LAST)_____

D.O.B:_____AGE:_____SEX:_____M_____F

SOCIAL SECURITY#_____

ADDRESS:
(STREET)_____

CITY:_____STATE_____ZIP_____

EMAIL:_____

PREFERRED PHARMACY/LOCATION:_____

PLACE OF EMPLOYMENT:_____

HOME#_____CELL#_____WORK:_____

MARITAL STATUS: SINGLE_____ MARRIED_____ WIDOWED_____ SEPARATED_____

NAME OF SPOUSE:_____

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY?

_____ PHONE#_____ RELATIONSHIP_____

NEAREST RELATIVE NOT LIVING WITH YOU:_____ PHONE_____

NEAREST FRIEND NOT LIVING WITH YOU:_____ PHONE_____

NAME OF GUARDIAN:_____ IF GUARDIAN, D.O.B._____

WHOM MAY WE THANK FOR REFERRING YOU TO US:

_____ PHONE#_____

WHO IS RESPONSIBLE FOR THIS BILL?

_____ PHONE#_____

I HAVE READ AND UNDERSTAND ALL THE INFORMATION ON THIS SHEET AND HAVE CONPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

PATIENT/GUARDIAN SIGNATURE:_____ DATE_____

Date___/___/_____

Patient Name:_____ DOB:_____

Patient Medical History Form (p.2): Please provide the following medical information to the best of your ability:

Review of Systems:

1. Please check the "Yes" or "No" box to indicate if you have any of the following symptoms.
2. For any "Yes" responses, please check the "current" box if this symptom relates to the reason for your visit today.

		Yes	No	Current		Yes	No	Current
GENERAL	Chills	___	___	___	Weight loss or gain	___	___	___
	Fatigue	___	___	___	Daytime sleepiness	___	___	___
ALLERGY	Environmental allergy	___	___	___	Sneezing fits	___	___	___
NEURO	Headache	___	___	___	Weakness	___	___	___
	Passing out	___	___	___	Numbness, tingling	___	___	___
EYES	Eye pain/pressure	___	___	___	Vision changes	___	___	___
ENT	Hearing loss	___	___	___	Ear noises	___	___	___
	Dizziness	___	___	___	Lightheadedness	___	___	___
	Nasal congestion	___	___	___	Sinus pressure or pain	___	___	___
	Hoarseness	___	___	___	Problem snoring, apnea	___	___	___
	Throat clearing	___	___	___	Throat pain	___	___	___
RESPIR.	Cough	___	___	___	Coughing blood	___	___	___
	Wheezing	___	___	___	Shortness of breath	___	___	___
CARDIAC	Chest pain	___	___	___	Palpitations	___	___	___
	Wake short of breath	___	___	___	Ankle swelling	___	___	___
GI	Difficulty swallowing	___	___	___	Heartburn	___	___	___
	Abdominal pain	___	___	___	Nausea/vomiting	___	___	___
	Bowel irregularity	___	___	___	Rectal bleeding	___	___	___
GU	Frequent urination	___	___	___	Painful urination	___	___	___
	Blood in urine	___	___	___	Prostate problems	___	___	___
HEME/LYM	Swollen glands	___	___	___	Sweating at night	___	___	___
	Bleeding problems	___	___	___	Easy bruising	___	___	___
ENDO	Feel warmer than others	___	___	___	Feel cooler than others	___	___	___
MSK	Joint aches	___	___	___	Muscle aches	___	___	___
SKIN	Rash	___	___	___	Hives	___	___	___
	Itching	___	___	___	Skin or hair changes	___	___	___
PSYCH	Depression	___	___	___	Anxiety or panic	___	___	___

PLEASE STOP HERE

Reviewed by:_____