						JP	INS	
					•	EST		·Y\$
	PA	TIENT HI	STORY FO	RM		DATE:		
PATIENT NAME:				DOI	3:	AG	E:	
ADDRESS					PHONE: _			
Note to return to wor	k/school (cir	cle one)	Yes No					
REASON FOR VISIT:								
MEDICATIONS (PRESC	RIPTION & 0	OVER THE	COUNTER)					
ALLERGIES (INCLUDE I	MEDICATION	NS, TYPE C	OF REACTIO	N)				
IMMUNIZATIONS (YEA	AR): Tdap	FLU_	COVID	)-19 P	NEUMOVA	XSH	INGLES	
PAST MEDICAL HISTOI	RY: (LIST ALL	CONDITI	ONS):					
SCREENINGS (YEAR CO FAMILY MEDICAL HIST CARDIAC HISTORY UN	ГОRY:							
SMOKING: YES/NO/FO	ORMER	ALCOHO	L: YES/NO		LMP	(FEMALE ON	ILY)	
		OFFIC	E USE ONLY	BELOW				
VITAL SIGNS: Height_	We	ight	BP	/	Temp _	HR	RR	SPo2
REVIEW OF SYSTEMS:	N, V, D, feve	er, weight	: loss, night	sweats, trav	vel, sexually	y active		
PHYSICAL EXAM:								
ORDERED/RESULTS:						In Lah	Book	
Leukocytes (120)	Neg	15+	70+	125++	500++			
Nitrites (60sec)	Neg	Pos						Strep
Urobilinogen (60)	Neg. 0.2	1	2	4	8	12		+ -
Pro (60)	Neg	15	30+	100++	300++	2000++		Flu

## PATIENT HISTORY FORM

				PHONE:			
:/school (cir	cle one)	Yes No					
R): Tdap	FLU	COVID	)-19 F	NEUMOVA	(SH	INGLES	
Y: (LIST ALL	. CONDITIO	ONS):					
MPLETED):	MAMM	O PA	.P B(	ONE DENSIT	Y CO	LONOSCOF	ΡΥ
ORY:							
DER THE AG	E OF 55: Y	ES/NO					
RMER	ALCOHO	L: YES/NO		LMP	(FEMALE ON	NLY)	
	OFFICE	USE ONLY					
							0. 0
					active		
					In Lab	Book	
Neg	15+	70+	125++	500++			
Neg	Pos						Strep
Neg. 0.2	1	2	4	8	12		+ -
Neg	15	30+	100++	300++	2000++		Flu
5.0	6.0	6.5	7.0	7.5	8.0	9.0	+ -
Neg	+	+	++	+++	5-10	50	HCG
1.000	1.005	1.010	1.015	1.020	1.025	1.030	+ -
Neg.	5	15	40	80	160		Covid
Neg.	1+	2++	4+++				+ -
Neg.	100	250	500	1000	≥2000		
		TREAT	MENT				
	AD	DRESS			PHOI	NE	
DER: NAME:	:			PHO	NE #:		
S	TUDENT_			1	IME		
	RIPTION & COMEDICATION R): Tdap Y: (LIST ALL MPLETED): ORY: DER THE AG RMER We N, V, D, feve N, V, D, feve Neg Neg Neg Neg Neg 1.000 Neg. Neg. Neg. Neg. OER: NAME:	RIPTION & OVER THE MEDICATIONS, TYPE OF RIPTION & OVER THE MEDICATIONS, TYPE OF RIPTIONS, TYPE OF RIPTIONS AND ADDER: NAME OVER THE AGE OF 55: YEAR ALCOHOLOGY:OFFICE OF THE AGE OF 55: YEAR ALCOHOLOGY AND ADDER: NAME OF THE AGE OF THE A	RIPTION & OVER THE COUNTER)  REDICATIONS, TYPE OF REACTIO R): Tdap FLU COVID RY: (LIST ALL CONDITIONS):  MPLETED): MAMMO PA ORY:  DER THE AGE OF 55: YES/NO  RMER ALCOHOL: YES/NO OFFICE USE ONLY  Weight BP N, V, D, fever, weight loss, night  Neg 15+ 70+ Neg Pos Neg. 0.2 1 2 Neg 15 30+ 5.0 6.0 6.5 Neg + + 1.000 1.005 1.010 Neg. 5 15 Neg. 1+ 2++ Neg. 100 250  TREAT	RIPTION & OVER THE COUNTER)	RIPTION & OVER THE COUNTER)	No   No   No   No   No   No   No   No	RIPTION & OVER THE COUNTER)



Info@yourfamilywalkinclinic.com

Office: 813-792-8555

Fax: 813-792-0555

17929 Hunting Bow Circle, Lutz, FL 33558

Patient Name:
CONTRACT TERMS
In order to protect our patients from outstanding debt and the risk of collections, an agreement has been made to improve the processing methods once insurance liabilities have been determined. This is not a receipt. This is a contract agreeing to pay for services once patient liability has been determined. The terms of this contract are as follows:
(guarantor initials) I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication of this and all other claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:
<ul> <li>a) The charges will take place upon receipt, or within a few days of the final explanation of benefits from my insurance company</li> <li>b) The amount charged to my card will not exceed \$200.00</li> <li>c) I will receive a bill from the practice for any balance greater than \$200.00 for which I am liable.</li> <li>d) I will receive a receipt for any amount charged to my card once the transaction has been executed</li> </ul>
Signature: X

(Cardholder signature) I agree to pay the above total amount according to the card issuer agreement.



Office: 813-792-8555

Fax: 813-792-0555

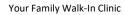
17929 Hunting Bow Circle, Lutz, FL 33558

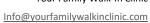


## **INFORMATION DISCLOSURE AND FINANCIAL POLICY**

I give Your Family Walk-In Clinic permission to disclose information regarding my health care to those listed
below. I understand that this authorization does not permit Your Family Walk-In Clinic or its representatives to
disclose copies of my medical records to the individuals listed.

dis	close copies	of my medical	records to the individuals	listed.	
•	Patient Nar	me	Birt	th date	
•	Name		Relationship		Phone Number
			s, we must obtain permis erson other than you.	ssion to leave me	edical information on voice mails,
DO	DO NOT	Leave medica	information on my home	e answering mad	chine. Number:
DO	DO NOT	Leave medica	information on my work	voicemail. Num	ber:
DO	DO NOT	Leave medica	information on my cell p	hone voicemail.	Number:
DO Ad		Mail informat	on to my home, other th	an billing inform	ation.
DO	DO NOT	Email commu	nications. Email:		
Fax					Fax number
onl res pla you Pay dec coi	ly you are responsibility for a covers and ur insurance yments that ductibles. Ad nsurance and	sponsible for upor the services what your find card.  you are responditional diagno	nderstanding the specificate of the specificate of the specification of	s of your insuran covided by our fa call the Member not limited to all redures may be s	rrier and the patient. Ultimately, you and ace plan. Your bear full financial acility. To find out what your insurance reservices number located on the back of copayments, coinsurance, and subject to separate copayments,
are ins	e responsible urance comp	for any additionany. By signing	nal payment responsibili	ties determined that you have p	service today, you understand that you after any claims are processed by your provided this facility with your correct harges.
and aff	d collection of ect a timely p	costs in the eve	nt of default payment. W Ir balance. We encourage	e understand th	y the reasonable attorney fees, interest at temporary financial problems may nicate such problems to us so that your
	_				patient named, your acknowledgement of our policies detailed above.





Office: 813-792-8555

Fax: 813-792-0555

17929 Hunting Bow Circle, Lutz, FL 33558

## **GENERAL INTAKE CONSENT AND HIPAA FORM**

Our Family WALK-IN CLINIC

IAME		IODA	Y'S DATE			
OCIAL SECURITY	#	DATE	OF BIRTH			
OME ADDRESS_		City	:	State	Zi <sub>l</sub>	D
HONE NUMBER_		EMAIL (REQUIRED)_				
MERGENCY CO	ONTACT					
IAME		RELAT	IONSHIP			
DDRESS		TELEPI	HONE NUMBER	l		
NSURANCE TYP	PE:			_ SELF	PAY [	]
OLICY HOLDER S	OCIAL SECURITY #	DATE C	F BIRTH			
HARMACY INF	ORMATION					
IAN4E	ADDRESS	ZIP	PHONE_			
IAIVIE						
RIMARY CARE	PROVIDER NAME:	T OF RECEIPT OF NOTICE with a copy of our Notice of Prrm to acknowledge receipt of	E <b>OF PRIVACY</b> ivacy Practices, very the Notice. You	PRACTION of the state of the st	CES es how	we may use and/o
PRIMARY CARE  Notice to Patient: Visclose your health ou wish. I acknowl	PROVIDER NAME:  ACKNOWLEDGEMEN  We are required to provide you we information. Please sign this fo	T OF RECEIPT OF NOTICE with a copy of our Notice of Prrm to acknowledge receipt of of this office's Notice of Priva	E OF PRIVACY ivacy Practices, v the Notice. You cy Practices.	PRACTION of the state of the st	CES es how v	we may use and/o
otice to Patient: Visclose your healthou wish. I acknowl	PROVIDER NAME:  ACKNOWLEDGEMEN  We are required to provide you we information. Please sign this for edge that I have received a copy	T OF RECEIPT OF NOTICE with a copy of our Notice of Prrm to acknowledge receipt of of this office's Notice of Priva	E OF PRIVACY ivacy Practices, v the Notice. You cy Practices.	PRACTION of the state of the st	CES es how v	we may use and/o
rint Name:  CONSENT TO  I, the undersign	PROVIDER NAME:  ACKNOWLEDGEMEN  We are required to provide you we information. Please sign this for edge that I have received a copy  Signature	T OF RECEIPT OF NOTICI with a copy of our Notice of Pr rm to acknowledge receipt of of this office's Notice of Priva ature:  alth care professionals who may	ivacy Practices, v the Notice. You cy Practices.  Date	PRACTION PRA	CES es how v se to sig	we may use and/o n this acknowledg
PRIMARY CARE  Notice to Patient: Visclose your health ou wish. I acknowled  rint Name:  CONSENT TO  I, the undersign diagnosis, care	PROVIDER NAME:  ACKNOWLEDGEMEN  We are required to provide you we information. Please sign this found the provide to the provide you we information. Please sign this found the provide that I have received a copy  Signator TREATMENT:	T OF RECEIPT OF NOTICE with a copy of our Notice of Pr rm to acknowledge receipt of of this office's Notice of Priva ature:  alth care professionals who may y or advisable by my healthcare p	ivacy Practices, v the Notice. You cy Practices.  Date	PRACTION PRA	CES es how v se to sig	we may use and/o n this acknowledg
rint Name:  CONSENT TO  I, the undersign diagnosis, care  GUARANTEI  I, the undersign diagnosis. I und which it is deteinsurance and a service charg claims knowing	ACKNOWLEDGEMEN  We are required to provide you was information. Please sign this found that I have received a copy  Signary  O TREATMENT:  med, consent to and authorize the head and treatment considered necessary	T OF RECEIPT OF NOTICE with a copy of our Notice of Pr rm to acknowledge receipt of of this office's Notice of Priva  ature:  alth care professionals who may y or advisable by my healthcare p  WENT OF INSURANCE BEN  It Your Family Walk-In Clinic may be ible for my co-payment, charges in gible to receive. Payment in full in surrance carrier. Payments made and the undersigned agrees to pay Florida statute s. 817.234. I also	be involved in my croviders.  EFITS:  Described at time by check or electroauthorize my provider my pr	PRACTION TO STATE TO STATE TO PROVIDE TO STATE TO PROVIDE TO STATE	es how vise to signification of the such a courter non-cover neluding that fail to corney's fease all in:	we may use and/o n this acknowledg this acknowledg with this acknowledg examinations, sy to my insurance ered services for copays, cotolers. Any fraudulent formation necessary
PRIMARY CARE  Notice to Patient: Visclose your health ou wish. I acknowled with the undersign diagnosis, care  GUARANTE!  I, the undersign benefits. I und which it is determined in the insurance and a service charge claims knowing to secure the province with the province of the province with the province of t	ACKNOWLEDGEMEN  We are required to provide you was information. Please sign this for edge that I have received a copy  Sign:  O TREATMENT:  The disconsent to and authorize the health and treatment considered necessary.  E OF PAYMENT AND ASSIGNATION and certifies that services provided at erstand that I am financially responsive from the I was out of network or ineligible deductibles as determined by your in e of \$30.00. If collections are requiredly committed are punishable under financially c	T OF RECEIPT OF NOTICE with a copy of our Notice of Pr rm to acknowledge receipt of of this office's Notice of Priva ature:  alth care professionals who may y or advisable by my healthcare p  MENT OF INSURANCE BEN  It Your Family Walk-In Clinic may be ible for my co-payment, charges of gible to receive. Payment in full is insurance carrier. Payments made and the undersigned agrees to pay Florida statute s. 817.234. I also close my health information to ca	be involved in my croviders.  EFITS:  De submitted on mot paid by insurant sexpected at time by check or electroauthorize my provierry out treatment,	PRACTION TO STATE TO STATE TO PROVIDE TO STATE TO PROVIDE TO STATE	es how vise to signification of the such a courter non-cover neluding that fail to corney's fease all in:	examinations,  sy to my insurance ered services for copays, co- o clear are subject to ees. Any fraudulent formation necessary