NP_____ INS_____
EST_____ COPAY$_____

PATIENT HISTORY FORM DATE: _____

PATIENT NAME: _____ DOB: _____ AGE: _____

ADDRESS_____ PHONE: _____

Note to return to work/school (circle one) Yes No

REASON FOR VISIT: _____

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER) _____

ALLERGIES (INCLUDE MEDICATIONS, TYPE OF REACTION) _____

IMMUNIZATIONS (YEAR): Tdap_____ FLU_____ COVID-19_____ PNEUMOVAX_____SHINGLES_____

PAST MEDICAL HISTORY: (LIST ALL CONDITIONS):

_____

SCREENINGS (YEAR COMPLETED): MAMMO_____ PAP_____ BONE DENSITY_____ COLONOSCOPY_____

FAMILY MEDICAL HISTORY: _____

CARDIAC HISTORY UNDER THE AGE OF 55: YES/NO _____

SMOKING: YES/NO/FORMER ALCOHOL: YES/NO LMP (FEMALE ONLY) _____

----------OFFICE USE ONLY BELOW----------

VITAL SIGNS: Height_____ Weight_____ BP_____/_____ Temp _____ HR_____ RR_____ SPo2_____

REVIEW OF SYSTEMS: N, V, D, fever, weight loss, night sweats, travel, sexually active

PHYSICAL EXAM: _____

ORDERED/RESULTS: _____In Lab Book_____

Leukocytes (120)	Neg	15+	70+	125++	500++		
Nitrites (60sec)	Neg	Pos					
Urobilinogen (60)	Neg. 0.2	1	2	4	8	12	
Pro (60)	Neg	15	30+	100++	300++	2000++	
pH (60)	5.0	6.0	6.5	7.0	7.5	8.0	9.0
Blood (60)	Neg	+	+	++	+++	5-10	50
Sp Gr (45)	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones (40)	Neg.	5	15	40	80	160	
Bilirubin (30)	Neg.	1+	2++	4+++			
Glucose (30)	Neg.	100	250	500	1000	≥2000	

Strep
+ -
Flu
+ -
HCG
+ -
Covid
+ -

DIAGNOSIS: _____ TREATMENT_____

FOLLOW UP: _____

PHARMACY: NAME_____ ADDRESS_____ PHONE_____

PRIMARY CARE PROVIDER: NAME: _____ PHONE #: _____

ROOM _____ STUDENT_____ TIME_____

Your Family Walk-In Clinic
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:

X _____(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:

a) The charges will take place upon receipt, or within a few days of the final explanation of benefits from my insurance company
b) The amount charged to my card will not exceed $200.00
c) I will receive a bill from the practice for any balance greater than $200.00 for which I am liable.
d) I will receive a receipt for any amount charged to my card once the transaction has been executed

Signature: **X**_____
(Cardholder signature) I agree to pay the above total amount according to the card issuer agreement.

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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.

- Patient Name _____ Birth date _____
  Phone Number _____ Parent/Guardian (If Minor) _____
- Name _____Relationship _____ Phone Number _____

According to HIPAA regulations, we must obtain permission to leave medical information on voice mails, answering machines or with person other than you.

DO DO NOT Leave medical information on my home answering machine. Number: _____
DO DO NOT Leave medical information on my work voicemail. Number: _____
DO DO NOT Leave medical information on my cell phone voicemail. Number: _____
DO DO NOT Mail information to my home, other than billing information.
Address: _____
DO DO NOT Email communications. Email: _____
Fax my medical information to my physician, Dr._____ Fax number _____

Insurance coverage is an arrangement made between the insurance carrier and the patient. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. Your bear full financial responsibility for the services rendered and products provided by our facility. To find out what your insurance plan covers and what your financial obligation may be, call the Member Services number located on the back of your insurance card.

Payments that you are responsible for include but are not limited to all copayments, coinsurance, and deductibles. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurance and deductibles than your office visit.

Though we collect your copayment or partial deductible at the time of service today, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company. By signing today, you acknowledge that you have provided this facility with your correct insurance information and no other insurance is responsible for these charges.

Delinquent accounts are turned over to TSI Collections. You agree to pay the reasonable attorney fees, interest and collection costs in the event of default payment. We understand that temporary financial problems may affect a timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Your signature represents your consent to treatment necessary for the patient named, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above.

X _____ X _____
Signature Date:

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GENERAL INTAKE CONSENT AND HIPAA FORM

NAME_____TODAY'S DATE_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

HOME ADDRESS_____ City _____ State _____ Zip_____

PHONE NUMBER_____**EMAIL (REQUIRED)**_____

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____

ADDRESS_____TELEPHONE NUMBER_____

INSURANCE TYPE: _____ SELF PAY ☐

POLICY HOLDER SOCIAL SECURITY #_____DATE OF BIRTH_____

PHARMACY INFORMATION

NAME_____ADDRESS_____ZIP_____PHONE_____

PRIMARY CARE PROVIDER NAME: _____ PHONE #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledge, if you wish. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

CONSENT TO TREATMENT:

I, the undersigned, consent to and authorize the health care professionals who may be involved in my care to provide such examinations, diagnosis, care and treatment considered necessary or advisable by my healthcare providers.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned certifies that services provided at Your Family Walk-In Clinic may be submitted on my behalf as a courtesy to my insurance benefits. I understand that I am financially responsible for my co-payment, charges not paid by insurance and for non-covered services for which it is determined I was out of network or ineligible to receive. Payment in full is expected at time of service including copays, co-insurance and deductibles as determined by your insurance carrier. Payments made by check or electronic debit that fail to clear are subject to a service charge of $30.00. If collections are required the undersigned agrees to pay all costs of collection, and attorney's fees. Any fraudulent claims knowingly committed are punishable under Florida statute s. 817.234. I also authorize my provider to release all information necessary to secure the payment of benefits and to use or disclose my health information to carry out treatment, payment, or health care operations.

I have read, understand, and agree to each of the statements contained in this document.

SIGNATURE_____ **DATE**_____

RELATIONSHIP (IF OTHER THAN SELF)_____