Broadway
Family Clinic

I _____read **Broadway Family Clinic's** Policy, Agreement for Treatment, Controlled Substance Agreement, Medication Management Agreement, Policy Changes and HIPAA Notice of Privacy Practices.

By signing my name below, I agree that I did read the above forms and it is **MY RESPONSIBILITY** to abide by these policies. I agree that I am responsible for reading these entirely. It is **MY RESPONSIBILITY** to know what is expected of me and what I can expect of my Provider.

_____

Patient's Signature Date

_____

Staff Members Signature Date

Broadway
Family Clinic

Consent for Medical Treatment

I give permission to **Broadway Family Clinic** to perform the following services that the physician's and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, diagnostic (e.g.: including, but not limited to, x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections and medications; and (c) completion of medically appropriate tests for communicable and other diseases.

Signature:_____ Date:_____

Consent for Wellness and Preventative Health Screening

I give permission for **Broadway Family Clinic** to perform a wellness and/or preventative health screening. I understand that I am solely responsible for following up with my personal physician or other healthcare provider about the results of my screening and that no other staff can release that information to me. In performing the wellness screening, **Broadway Family Clinic** does not assume any responsibility for ongoing treatment or management of care.

Signature:_____ Date:_____

Broadway Family Clinic
612 State Highway 25 South Bloomfield MO 63825
Phone: 573-568-7377 OR 573-803-3995
Fax: 573-803-5222

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

Social Security#_____/_____/_____ **Date of Birth**_____/_____/_____ **Male**____ **Female**___

Mailing Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell**_____

Emergency Contact Name_____

Phone Number_____

Primary Insurance_____

Member ID _____

Policy Holder's Name_____ **Date of Birth**_____/_____/_____

Secondary Insurance_____

Member ID _____

Policy Holder's Name_____ **Date of Birth**_____/_____/_____

Patient/Guarantor Signature_____**Date**_____/_____/_____

Broadway
Family Clinic

A federal regulation known as the **HIPAA Privacy Rule** requires that we provide you with a detailed notice in writing of our privacy practices. It also requires us to address any special needs you may have to ensure your patient information is kept confidential.

May we call and remind you of your appointments?May we leave a message on your voicemail? Yes No

May we leave results of your diagnostic test on your voicemail if you're not available? Yes No

May we call you at work with test results or other health-related issues? Yes No

Other than yourself, do you authorize our office to discuss your health information/testing with anyone? Yes No

Please list anyone we may discuss your health information with below:

_____Relationship_____Phone:_____

_____Relationship_____Phone:_____

Consent for Purpose of Treatment, Payment and Healthcare Services

I consent to the use or disclosure of my protected health information of the purposes of diagnosing or providing treatment to and/ or obtaining payment for my healthcare charges.

In the event that any person assisting in the provision of care and treatment suffer inadvertent exposure, capable of transmitting disease, to any of my blood and / or other bodily substances and I am unable to timely consult with the doctor prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of, Hepatitis B, and C and HIV.

I have been given a copy of this offices Notice of Privacy Practices. I have been given the right to review such Notice of Privacy Practices prior to signing this agreement.

_____ _____

Patient Name **Patient Signature**

_____ _____

Legal Guardian **Signature**

_____ _____

Date **Date**

_____ _____

Witness Name **Witness Signature**

Broadway Family Clinic

Patient Name_____ **Date of Birth**_____/_____/_____

Past Medical History

Please check all that apply:

Head Trauma____

EYES:
Blindness____
Cataracts____
Glaucoma___
Glasses or contacts____

EARS:
Hearing Aids____

NOSE/SINUSES:
Allergic Rhinitis____
Sinus Infections____

ENDOCRINE:
Goiter____
Hyperlipidemia____
Hypothyroidism___

MOUTH/THROAT/TEETH:
Dentures_____

CARDIOVASCULAR:
Aneurysm_____
Angina____
DVT_____
Dysrhythmia_____
High Blood Pressure_____
Murmur_____
Myocardial Infarction_____
Other Heart Disease_____

Thyroid Disease_____
Thyroiditis____
Type I Diabetes____
Type II Diabetes____

RESPIRATORY:
Asthma_____
Bronchitis____
COPD_____
Pleuritis____
Pneumonia____

GENITOURINARY:
Hernia_____
Incontinence____
Nephrolithiasis____
Other Kidney Disease____
STDs_____
UTIs_____

INFECTIOUS:
HIV____
STDs____
Tuberculosis (disease)____

GASTROINTESTINAL:
Cirrhosis_____
GERD_____
Gallbladder Disease_____
Heartburn____
Hemorrhoids_____
Hepatitis_____
Hiatal Hernia____
Jaundice_____
Ulcer_____

MUSCULOSKELETAL:
Arthritis____
Gout____
M/S Injury____

Tuberculosis (exposure) ____

SKIN:
Dermatitis____
Moles____
Other Skin Conditions____
Psoriasis_____

NEUROLOGICAL:
Epilepsy____
Seizures____
Headaches____
Migraines____
Stroke____
TIA_____

PSYCHIATRIC:
Bipolar Disorder____
Depression____
Hallucinations____
Delusions____
Suicidal Ideation____
Suicide Attempts_____

HEME/ONC:
Anemia____
Cancer_____

Are you allergic to any medications? If yes please list: _____
_____

Any severe injuries? Please list: _____
_____

Any surgeries? Please list: _____
_____

Any Hospitalizations? Please list: _____
_____

SOCIAL HISTORY

Tobacco:
Current every day smoker____
Current some day smoker____
Former smoker____
Heavy tobacco smoker____
Light tobacco smoker____
Never smoker____
If smoker, how many packs per day_____

Alcohol:
Do not drink_____
Drink daily_____
Frequently drink_____
History of alcoholism____
Occasional drink____

Drug Abuse:
IV drug use____
Illicit drug use____
No illicit drug use____

Cardiovascular:
Eat healthy meals____
Regular exercise_____
Take daily aspirin____

Sexual Activity:
Exposure to STI_____
Not sexually active____
Safe sex practices____
Sexually active_____

Birth Gender:
Male____
Female____

For Female Patients:
Age onset of Menses_____
Age at Menopause_____
History of abnormal PAP smear_____
History of cervical biopsy___
Total Pregnancies_____
Full Term____
Pre-Term____
Miscarriages_____
Living____

Broadway
Family Clinic

RELEASE OF INFORMATION

Patient Name :_____

SSN:_____/_____/_____ Date of Birth:_____/_____/_____

Maiden names or aliases, if applicable: _____

I authorize_____

To disclose or provide protective health information about me to:

Broadway Family Clinic

P:573-803-3995 or 573-568-7377

F:573-803-5222

Information Requested:

_____

_____

I understand that if records are released to me personally, there will be a fee charged to me. I understand that I may refuse to sign and agree with this release, but in doing so, I will not have access to my records. Expiration or termination of authorization: This authorization will expire upon completion of this transaction. You will have the right to terminate this authorization at any time. This request will be honored except to the extent of any action already taken before the revocation of authorization.
Right to revoke or terminate: As stated in Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request.

Patient Signature :_____

Date_____/_____/_____

This Release of Information is good for up to one year from the above date.

Staff Signature:_____