FAMILIES FIRST MEDICAL GROUP

11555 Central Parkway, Suite #402, Jacksonville, FL 32224

Phone: (904) 747-3800 Fax: (904) 747-3733

Kia M. Mitchell, MD Thanh Nguyen, MD

Myeshia Carter MSN, APRN, Brandy Fulton, MSN, APRN

Immunization History: Please provide a copy of shot records

Patient's Full Legal Name_____Date_____

Nickname or name patient goes by _____

Address_____Child's SS# _____

City, State, Zip _____

Phone # _____ Birth Date_____Sex (circle) Male Female

Hospital of Birth _____City_____State_____

Brother/Sisters we have seen _____

Whom may we thank for referring you to our office? _____

_____ Father's

Mother's

Full Name_____Full Name _____

Employer Employer

_____ _____

Work Phone Work Phone

_____ _____

Cell#

_____Cell #_____

Email Address

_____Email Address _____

SS#

_____SS# _____

Father's Date of Birth

Driver's License No. _____Mother's Date of Birth _____

_____Driver's License No. _____

Name of the patient's legal guardian(s) (if other than parents) _____

Preferred Pharmacy:_____

Insurance Information (Primary coverage)

Name of Person Holding Policy _____

Relationship to Patient _____

Insurance Co. Name _____ Policy # _____

Address _____ Group # _____

Address con't _____ Phone # _____

City, State, Zip _____ Effective date coverage began _____

Insurance Information (Secondary)

Name of Person Holding Policy _____

Relationship to Patient _____

Insurance Co. Name _____ Policy # _____

Address _____ Group # _____

Address con't _____ Phone # _____

City, State, ZIP _____ Effective date coverage began _____

Birth History:

Gestational Age (Weeks of pregnancy)	
Birth Weight	
Birth Length	
Type of Delivery (C/S or Vaginal)	
Hospital Stay (Days or Weeks)	
Complications	

Social History:

Who lives in the home?	
Name of school or day care	
Is patient a smoker? (If yes, how many packs per day)	
Exercise or sport activities	

Family History:

☐ Sickle Cell
☐ Asthma
☐ Diabetes
☐ Other (please explain)

Past Medical / Surgical History:

Patient Allergies:

Medications	
Food	
Other	

Medications:	**Dosage:**

I hereby authorize Families First Medical Group to render any medical care they deem necessary in the treatment of my child.

Signature of parent/guardian _____ Date _____

(*OK to send records requested by specialists for evaluation and treatment of your child)*

Patient's Name_____Date of Birth_____

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EMERGENCY CARE/CONSENT FOR TREATMENT

Patient's Name_____Date of Birth _____

I hereby give permission to all of the providers of Families First Medical Group to direct any emergency medical treatment to my children during my absence. It is understood that they will make every effort to contact me in case of a medical emergency. It is further understood that if they are unable to contact me, I give them this permission with my full consent.

If hospitalization is necessary, I direct the providers of Families First Medical Group to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well care, immunizations, minor illnesses, etc.), it is necessary for you to list the individuals to whom you have given permission to bring the child in for care.

Please list below:

Name:	Relationship to Child (aunt, neighbor, etc.):

Signature of parent/ guardian_____Date _____

Witness:_____(FFMG Staff)

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OUR FINANCIAL POLICY

Your understanding of our FINANCIAL POLICY is important to us. Please let us know if have any questions about our fees, financial policy or your responsibilities.

*CO-PAY, CO-INSURANCE, DEDUCTIBLES AND BALANCES ARE DUE AT THE TIME OF SERVICE

*WE ACCEPT CASH, VISA, MASTERCARD & DISCOVER

*NO SHOW FEE: 24-hour notice for cancellation must be given or there will be $50.00 no show fee added to your account which must be paid prior to your next visit.

*MINORS WHO ARE SEEN IN OUR OFFICE
An adult must accompany all minors and full payment is due at the time of service. If your child is old enough to come to our office on his/her own, they will also be required to pay at the time of service.

* BILLING
Families First Medical Group does not bill or extend credit. You are required to pay your co- pay, deductible, or any balance due at the time of service. We cannot hold checks. If you have an emergency situation or an issue that will prevent you from paying for your service, please contact our billing department in advance and they will discuss arrangements with you.

* INSURANCE
If we accept your insurance, you are responsible for any deductibles, co-insurance or co-pays at the time of service. IF YOUR INSURANCE CARRIER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY US WHEN CHECKING IN. IF YOU FAIL TO DO SO, YOU MAY BECOME RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT. Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account.

*The parent/ guardian who brings the child in for the appointment is responsible for payment.

*I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, not covered by insurance. I have read all of the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Parent/Guardian_____Date_____

FAMILIES FIRST MEDICAL GROUP

Privacy Policy Notification

INTRODUCTION

Families First Medical Group is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Families First Medical Group has created a Privacy Policy. The purpose of this notification is to familiarize you with the existence of our policy, as well as give you an overview of its contents. The full-written policy is available to you on request.

HIGHLIGHTS

Your Rights: You have a right to inspect and copy your protected health information. You have a right to request a restriction of your protected health information. You have the right to have your physician amend your health information. You have a right to receive an accounting of disclosures of your protected health information.

Families First Medical Group will use your private information in a variety of ways to facilitate your care. Some of these uses require your written consent and some do not. Private information (termed Protected Health Information or PHI in HIPPA), includes anything which individually might identify you (Name, SSN, diagnoses, etc.).

Families First Medical Group may use your PHI without written consent to communicate with emergency rooms, hospitals, specialists, lab and x-ray facilities, and other facilities involved in the current treatment of the patient. In addition, Families First Medical Group will routinely use PHI in the submission of billing to insurance companies. Also, any release required by law (mandatory notification of contagious disease to the health department, issues involving abuse or neglect, adverse drug and treatment reports to the FDA, issues involving criminal activity to law enforcement, or other releases required by law) may take place.

Families First Medical Group your written consent to release PHI to parties other than those listed above. This includes release to relatives other than immediate caregivers, to attorneys, to employers, to life insurance or disability insurance carriers, to research projects, or any others not listed previously.

Families First Medical Group Clinic does have business relationships with some companies who might periodically have access to your PHI. These include our attorneys, practice management consultants, computer system consultants and others. The purpose of these situations is for these entities to advise us, internally, on our practice operations. Families First Medical Group maintains a contractual agreement with these entities which restricts their use of private information to their business relationship with us.

Families First Medical Group does increasingly use computer systems to transmit private information. This is largely to transmit claim and referral information with insurers and to exchange private information with other health care facilities. HIPPA mandates the secure electronic transmission of private information, and we are in compliance with those requirements.

Families First Medical Group use PHI during the day-to-day operations of the office. While certain uses of PHI (such as calling you by name in the waiting

room) are acceptable, others (such as a person overhearing a telephone call regarding your case) are not. We are committed to preventing inadvertent disclosures. Your feedback about how we are doing in this or any other area is strongly encouraged.

Signed by Patient / Guardian:_____Date:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Patient Name_____Patient SS#_____ DOB _____

Patient's Address_____

I hereby authorize **Families First Medical Group to (please check one of the following):**

☐ **Obtain copies of my medical record (s) from:**☐ **Release copies of my medical record (s) to**:

Name_____

Address _____

Phone Number _____Fax Number _____

Information as identified below is to be released:*(circle all that apply)*

All Medical Records	Emergency Room Report	Mental/Behavioral Health Notes
Progress Sheets/Clinic Notes	Cardiac Rehab	X-ray Reports
Doctors Orders	Operative Report	Pulmonary Rehab
Lab/Pathology Report	Occupational Health	Immunization Record
PT/OT/ST	Psychological Report	History & Physical
Discharge Summary	Chemical Dependency	Other_____
History & Physical		

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable diseases (*if any such information exists),*
may be released unless otherwise specified above.

**This information is needed for the following purpose(s):_____

HIPAA Privacy Rule. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

This authorization will automatically expire ninety (90) days following the date of signature.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient_____Date _____

Signature of Parent or Legal Guardian _____Date _____

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Witness _____(Staff Name) Date _____