Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Patient Demographics

Welcome to Unity Family Health Care, we are pleased to have you in our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we will be glad to help.

Name:_____
Last First MI (Preferred)
Patient address:_____
Address City State Zip code

Birthdate_____ SS#_____ Sexual Orientation:_____Gender at Birth :_____
Gender Identity:_____ Preferred Pronoun/s:_____Marital Status:_____
Work phone: _____Wireless Phone: _____ Home Phone: _____
Email: _____
Preferred contact method: _____
Student status if dependent over 19 (for insurance) _____

How did you hear about us? _____

Emergency Contact: _____
Phone #: _____ Relation: _____

Release of Information:
Who may we release information to over phone: _____ Relation: _____
Who may we release medical records to: _____ Relation: _____

Insurance Policy 1 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

Insurance Policy 2 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

Insurance Policy 3 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Patient History

Patient Name: _____ DOB: _____

Allergies (please list your reaction and when it started):_____
_____
_____

Current Medications/Dosage/Prescriber:_____
_____
_____
_____

Personal Medical History: (Please circle all that apply)

☐ ADHD	☐ Crohn' Disease	☐ Headache/Migraine	☐ Osteopenia/Osteoporosis
☐ Alcoholism	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Allergies, Seasonal	☐ Dementia	☐ Kidney Disease	☐ Peripheral Vascular Disease
☐ Anemia	☐ Depression	☐ Kidney Stones	☐ Peptic Ulcer
☐ Anxiety	☐ Diabetes 1 or 2	☐ High Cholesterol	☐ Psoriasis
☐ Arrhythmia (Irregular heartbeat)	☐ Diverticulitis	☐ HIV	☐ Pulmonary Embolism (PE)
☐ Arthritis	☐ DVT (Blood clot)	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Asthma	☐ GERD (Acid reflux)	☐ Irritable Bowel Syndrome	☐ Seizure Disorder
☐ Bipolar Disorder	☐ Glaucoma	☐ Lupus	☐ Sleep Apnea
☐ Bladder Problems/Incontinence	☐ Heart Disease	☐ Liver Disease	☐ Stroke
☐ Bleeding Problems	☐ Heart Attack	☐ Macular Degeneration	☐ Thyroid Disorder
☐ Cancer: _____	☐ Hiatal Hernia	☐ Neuropathy	☐ Ulcerative Colitis

Patient Name:_____ DOB:_____

Have you had any possible exposure to Hepatitis or HIV/Aids? ☐ Yes ☐ No

Other medical problems not listed above:_____
_____
_____

Family History:

Father: Living age: _____ Deceased age: _____

O Alcoholism	O Bipolar Disorder	O Depression	O High Cholesterol	O Osteoporosis
O Anemia	O Cancer: _____	O Diabetes 1 or 2	O High Blood Pressure	O Stroke
O Asthma	O COPD/Emphysema	O DVT (blood clot)	O Kidney Disease	O Thyroid Disorder
O Arthritis	O Dementia	O Heart Disease	O Migraines	

Other:_____

Mother: Living age: _____ Deceased age: _____

O Alcoholism	O Bipolar Disorder	O Depression	O High Cholesterol	O Osteoporosis
O Anemia	O Cancer: _____	O Diabetes 1 or 2	O High Blood Pressure	O Stroke
O Asthma	O COPD/Emphysema	O DVT (blood clot)	O Kidney Disease	O Thyroid Disorder
O Arthritis	O Dementia	O Heart Disease	O Migraines	

Other:_____

Siblings:
_____
_____
_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney doctor, Dentist. Etc.)
_____
_____
_____
_____

Surgical History (Do you have any implants? If yes, please explain):_____
_____
_____
_____
_____
_____

Patient Name:_____ DOB:_____

Social/Cultural History:

Are you or have you ever been a smoker? ☐ Yes ☐ No If yes, amount/duration of use: _____

Are you or have you ever used vaping products? ☐ Yes ☐ No If yes, amount/duration of use: _____

Are you or have you ever used recreational drugs? ☐ Yes ☐ No If yes, amount/duration of use: _____

Have you ever received a blood transfusion? ☐ Unknown ☐ Yes ☐ No
If yes, approximate year(s) ago: _____

Are you sexually active? ☐ Yes ☐ No

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

If you marked yes to any of the above, please explain:_____

_____

_____

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Marital Status: Are you currently married? ☐ Yes ☐ No

Current Spouse: ☐ Not applicable ☐ Alive (Age _____) ☐ Deceased (Age_____)

Information: Health problems or cause of death: _____

If alive, current employment status: ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Employed – current occupation(s):
_____

Patient Name:_____ DOB:_____

Occupational and/or Military History:

When did you begin working and what type of jobs have you held?

_____

_____

What is your current occupation? _____

How long have your worked at your present job? _____

Are you a veteran? ☐ Yes ☐ No If so, what branch of service? _____ Date of Discharge_____

Were you involved in combat? ☐ Yes ☐ No

OB/GYN History:

Date of last Pap smear: _____ STIs/STDs: ☐ Yes ☐ No

History of abnormal Pap smear? ☐ Yes ☐ No Have you had an HPV Vaccine? ☐ Yes ☐ No

Sexual Problems or concerns you wish to address: _____

Date of LMP: _____ Duration: _____Days Menstrual Cycle: ☐ Regular ☐ Irregular

Menses monthly? ☐ Yes ☐ No Flow: ☐ Light ☐ Moderate ☐ Heavy

Birth Control:

Current birth control method: _____ Desired birth control method: _____

Pregnancy History:

Age at first childbirth? _____ Number of Pregnancies: _____ Full term: _____ Living: _____

Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize **UNITY FAMILY HEALTH CARE, INC**. and its affiliates, its employees and agents, to use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, and member ID number) for the purpose of helping me to resolve claims and health coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. **If applicable, Legal Representatives, sign below:**

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Consent for Procedure/Treatment

I hereby authorize and direct Unity Family Health Care, Inc. and assistants, as necessary to perform quality care, to perform appropriate procedure/treatment(s) on me.

The nature and purpose of the procedure/treatment(s), alternative methods of treatment, and potential risks and complications will have been fully explained to me.

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Office Policies

- Refills: Please contact your pharmacy for refills. The pharmacy will contact us with the appropriate information. **Please allow 24 hours for this to take place**.
- Social Media: Please refrain from messaging ALL staff on office social media sources (i.e. Facebook) or their personal social media regarding any health concerns you may have. Social media is not a secure means of communication of sensitive information, also, we cannot guarantee we will be using social media and will receive your message. All patients need to call the office, regardless of the time of day and leave a message on the phone and our staff will get back to you. **All messages received by staff regarding personal medical information/concerns will not be replied to and will be discarded promptly**.
- Inclement weather: Staff will be in office if weather permits. If the staff deems it unsafe to travel, the office will delay opening or remain closed. The safety of our patients and staff is our priority. Should you have any questions about closures, please call the office phone number 304-500-2567 or check the office Facebook page for updates.
- No-shows: Failure to give 24-hour notice of an appointment cancellation may result in a fee of $25.
- Insufficient Funds: Should payment be returned for insufficient funds; your account will be charged a fee of $35.
- Late Arrivals: Patients arriving more than 15 minutes late for their appointment, may be rescheduled for another time. Our office staff will try to fit you into the current schedule; however, this is not always possible, and you may be required to wait or return at a later time.
- Cell Phone Usage: Providers will not conduct ANY exam if the patient or parent/guardian of a minor child is on their cell phone in the exam room. This includes playing games or listening to music. Feel free to use your phone when staff is not in the room. This ensures the best possible evaluation and care.
- Form Completion: Forms requiring a healthcare official to complete, including short term disability, social security, FMLA, medication administration, and letters requested by the patient, will cost $25 per form. Medical records requested will cost $25. Payment is due at time of delivery.
- Copays: Copays and outstanding balances are to be paid at the time of service.
- Children of Divorced Parents: Payments are due at the time of presentation, regardless of which parent accompanies the patient during the office visit.
- Current Patient Status: To be considered an active patient at Unity Family Health Care, you must be seen at least annually for a physical exam.
- Mutual Respect: We will treat patients and family members with respect and courtesy, and we appreciate the same in return for our staff members.
- Chronic Pain/Anxiety Management: This practice does **NOT** utilize narcotics, opiates, or benzodiazepines for chronic pain management or anxiety.
- Treatment Rooms: Due to limited room size, we request that individuals in patient rooms be limited to the patient and ONE parent/guardian if patient is a child unless otherwise arranged with staff. This is to ensure there is enough room for the provider and nurse in the treatment room.
- Termination: Patients may be terminated from practice at the providers discretion should the situation warrant.

Signature_____ **Date**_____