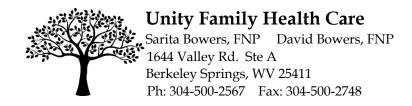


#### **Patient Demographics**

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 Bir	th :	
Gender Identity:	Preferred Pronoun	/s:Marital	Status:		
Work phone:	Wireless Phone	e: Home Ph	one:		
Email:					
Preferred contact method	1:				
		e)			
How did you hear about	us?				
Emergency Contact:					
Phone #:	Relatio	on:			
W/1		Release of Information:	- <b>4</b> •		
		Rel			
who may we release me		Rel	ation:		
	Insurance	Policy 1 (Please provide card to	reception)		
Subscriber Name:		Subscriber ID#			
Insurance Company:		Phone:		-	
Employer:	Group Na	Phone: Group Name: Group #_			
Relationship to Subscrib	er		A		
Ĩ	Insurance	Policy 2 (Please provide card to	reception)		
Subscriber Name:		Subscriber ID#			
		Phone:			
Employer:	Group Na	ume:	Group #		
Relationship to Subscrib	er		1		
	Insurance	Policy 3 (Please provide card to	recention)		
Subscriber Name:		Subscriber ID#			
		Phone:		-	
		I none:	Group #		
Relationship to Subscrib			r ··		



# Patient History

	DOB:					
ion and when it started):						
rescriber:						
Please circle all that apply)	1					
Crohn' Disease	Headache/Migraine	Osteopenia/Osteoporosis				
COPD/Emphysema	High Blood Pressure	Parkinson's Disease				
Dementia	Kidney Disease	Peripheral Vascular Disease				
Depression	☐ Kidney Stones	Peptic Ulcer				
Diabetes 1 or 2	High Cholesterol	Psoriasis				
Diverticulitis	$\square$ HIV	Pulmonary Embolism (PE)				
DVT (Blood clot)	Hepatitis	Rheumatoid Arthritis				
GERD (Acid reflux)	Irritable Bowel Syndrome	Seizure Disorder				
Glaucoma	Lupus	Sleep Apnea				
Heart Disease	Liver Disease	Stroke				
Heart Attack	Macular Degeneration	Thyroid Disorder				
🗌 Hiatal Hernia	Neuropathy	Ulcerative Colitis				
	ion and when it started): rescriber: Please circle all that apply) Crohn' Disease COPD/Emphysema Dementia Depression Diabetes 1 or 2 Diverticulitis DVT (Blood clot) GERD (Acid reflux) Glaucoma Heart Disease Heart Attack	ion and when it started): rescriber: Please circle all that apply) Crohn' Disease   Headache/Migraine COPD/Emphysema   High Blood Pressure Dementia   Kidney Disease Depression   Kidney Stones Depression   High Cholesterol Diabetes 1 or 2   High Cholesterol Diverticulitis   HIV DVT (Blood clot)   Hepatitis GERD (Acid reflux)   Irritable Bowel Syndrome Glaucoma   Lupus Heart Disease   Liver Disease Heart Attack   Macular Degeneration				

Patient Name:				DOB:			
Have you had any possible exposure to Hepatitis or HIV/Aids? $\Box$ Yes $\Box$ No							
Other medica							
Family His	tory:						
Father:	Living age:		Deceased age	:			
OAlcoholism OAnemia OAsthma OArthritis Other:	<ul> <li>O Bipolar Disorder</li> <li>O Cancer:</li> <li>O COPD/Emphysema</li> <li>O Dementia</li> </ul>	O DVT (blood clot O Heart Disease	<ul> <li>O High Cholesterol</li> <li>O High Blood Pressure</li> <li>C Kidney Disease</li> <li>O Migraines</li> </ul>	O Osteoporosis O Stroke O Thyroid Disorder			
Mother:	Living age:		Deceased age	:			
OAlcoholism OAnemia OAsthma OArthritis	<ul> <li>O Bipolar Disorder</li> <li>O Cancer:</li> <li>O COPD/Emphysema</li> <li>O Dementia</li> </ul>	O DVT (blood clot O Heart Disease	<ul> <li>O High Cholesterol</li> <li>O High Blood Pressure</li> <li>O Kidney Disease</li> <li>O Migraines</li> </ul>	O Osteoporosis O Stroke O Thyroid Disorder			
Other: Siblings:							
		·····					
List other me	edical providers you see o	n a regular basis (i	.e. Cardiologist, Mental	Health Provider, Kidney doctor, Dentist. Etc.)			
<u>Surgical Hi</u>	istory (Do you have an	iy implants? If y	es, please explain):				

Patient Name	::
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#### Social/Cultural History:

Are you or have you ever been a smoker? $\Box$ Yes $\Box$ 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? $\Box$ Yes $\Box$ No					
Education Level:  Elementary  High School  Vocational  College  Graduate/Professional					
Are there any vision problems that affect your communication? $\Box$ Yes $\Box$ No					
Are there any hearing problems that affect your communication? $\Box$ Yes $\Box$ No					
Are there any limitations to understanding or following instructions (either written or verbal)? $\Box$ Yes $\Box$ No					
Are there any personal problems or concerns at home, work, or school you would like to discuss? $\Box$ Yes $\Box$ No					
Are there any cultural or religious concerns you have related to delivery of care? $\Box$ Yes $\Box$ No					
Are there any financial issues that directly impact your ability to manage your health? $\Box$ Yes $\Box$ No					
If you marked yes to any of the above, please explain:					
Current Living Situation (Check all that apply):       Single       Multi-       Skilled         Single       Multi-       Skilled       Other:         Family       generational       Homeless       Shelter       Nursing         Household       Household       Facility					
How often do you get the social and emotional support you need?					
$\Box$ Always $\Box$ Usually $\Box$ Sometimes $\Box$ Rarely $\Box$ 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: $\Box$ Retired $\Box$ Unemployed $\Box$ Homemaker $\Box$ Employed – current occupation(s):					

Patient Name: I	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? $\Box$ Yes $\Box$ No If so, what branch of service?	Date of Discharge
Were you involved in combat?   Yes No	
<u>OB/GYN History</u> :	
Date of last Pap smear: STIs/STDs:  _ Yes  _ N	No
History of abnormal Pap smear? □ Yes □ No	tine? 🗆 Yes 🗆 No
Sexual Problems or concerns you wish to address:	
Date of LMP: Duration:Days Menstrual Cycle: D	egular 🗆 Irregular
Menses monthly? $\Box$ Yes $\Box$ No Flow: $\Box$ Light $\Box$ Moderate $\Box$ Heat	vy
Birth Control:	
Current birth control method: Desired birth control method:	
Pregnancy History:	
Age at first childbirth? Number of Pregnancies: Full term:	Living:



### 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.



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).

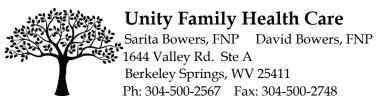
I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature:

Date: \_\_\_\_\_

Witness Signature:

Date: \_\_\_\_\_



# **Office Policies**

- <u>Refills</u>: Please contact your pharmacy for refills. The pharmacy will contact us with the appropriate information. <u>Please allow 24 hours for this to take place</u>.
- <u>Social Media:</u> Please refrain from messaging <u>ALL</u> 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. <u>All messages received by staff regarding personal medical</u> <u>information/concerns will not be replied to and will be discarded promptly</u>.
- <u>Inclement weather</u>: 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.
- <u>No-shows</u>: Failure to give 24-hour notice of an appointment cancellation may result in a fee of \$25.
- <u>Insufficient Funds</u>: Should payment be returned for insufficient funds; your account will be charged a fee of \$35.
- <u>Late Arrivals</u>: 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.
- <u>Cell Phone Usage</u>: 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.
- <u>Form Completion</u>: 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.
- <u>Copays</u>: Copays and outstanding balances are to be paid at the time of service.
- <u>Children of Divorced Parents</u>: Payments are due at the time of presentation, regardless of which parent accompanies the patient during the office visit.
- <u>Current Patient Status</u>: To be considered an active patient at Unity Family Health Care, you must be seen at least annually for a physical exam.
- <u>Mutual Respect</u>: We will treat patients and family members with respect and courtesy, and we appreciate the same in return for our staff members.
- <u>Chronic Pain/Anxiety Management</u>: This practice does <u>NOT</u> utilize narcotics, opiates, or benzodiazepines for chronic pain management or anxiety.
- <u>Treatment Rooms</u>: 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.
- <u>Termination</u>: Patients may be terminated from practice at the providers discretion should the situation warrant.

Signature				

Date						
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