Access Family Health / Wellness Practices of America

**Shaun Kelehan, MD**

 **Austin Davidson, FNP-C Jayasree Krishnankutty, PA-C**

1420 W Wells Branch Parkway, Suite 450, Pflugerville, TX 78660 **Phone: 512-806-0201 Fax: 737-300-1420**

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First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M. Init.: \_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_M \_\_\_F

SSN: \_\_\_\_\_\_\_ **-** \_\_\_\_\_\_ **-** \_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best # to Call? \_\_\_Home \_\_\_Cell \_\_\_Work

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext #: \_\_\_\_\_\_\_\_\_\_

Are You a College Student? \_\_\_\_Yes \_\_\_\_No If Yes, what College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What name do you generally go by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency, list two people you wish us to contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Information on the Health Insurance Policy Holder (Insurer) ONLY**.

\_\_\_\_**Self** Please Complete the following if the Policy Holder someone other than yourself.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_ **-** \_\_\_\_\_\_ **-** \_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures they refer to as “Reasonable & Customary Fee.” We do not accept this as payment in full. Also, some of the insurance companies only pay a percentage of the charge. It is the patient’s responsibility to pay any deductible amount, co-insurance or any other balance not paid for you your insurance. Co-insurance is due at the time of the visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Access Family Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

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**Health History**

Have you had or do you suffer from the following? (Check for Yes)

\_\_\_\_ High Blood Pressure \_\_\_\_ Congestive Heart Failure \_\_\_\_ Reflux

\_\_\_\_ Diabetes Mellitus \_\_\_\_ Angina Pectoris \_\_\_\_ Peptic Ulcer Disease

\_\_\_\_ High Cholesterol \_\_\_\_ Heart Disease \_\_\_\_ Diverticulosis

\_\_\_\_ Thyroid Disease \_\_\_\_ Atrial Fibrillation \_\_\_\_ Hemorrhoids

\_\_\_\_ Stroke \_\_\_\_ Irregular Heart Beat \_\_\_\_ Kidney Disease

\_\_\_\_ Migraines \_\_\_\_ Asthma \_\_\_\_ Anemia

\_\_\_\_ Arthritis \_\_\_\_ Tuberculosis \_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ COPD \_\_\_\_ Pneumonia \_\_\_\_ Bleeding Abnormality

\_\_\_\_ Heart Attack \_\_\_\_ Bronchitis \_\_\_\_ Kidney Stones

\_\_\_\_ Depression \_\_\_\_ Liver Disease \_\_\_\_ Seizures

\_\_\_\_ Glaucoma \_\_\_\_ Prostate Disease \_\_\_\_ Urinary Tract Infection

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES:** List ALL Surgeries and Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATION ALLERGIES:** List ALL medications that you are allergic to and what happens when you take it.

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS:**

MEDICATION DOSE (STRENGTH) # TAKEN DAILY REASON FOR TAKING

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient’s Family and Social History**

**Family History:**  Yes Family Member **Tobacco History:**

Heart \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Never Currently Former How Long?

Blood Pressure \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (circle one)

Diabetes \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smoking \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_ mo. yrs.

Bleeding Disorder \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chewing \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_\_ mo. yrs.

Auto-Immune Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you’re a current smoker, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alcohol History:**

Other \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Never \_\_\_\_\_ In the Past

**Explain “Yes” Answers/Family Members:** \_\_\_\_\_ Occasionally \_\_\_\_\_ Moderate to Heavy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Marital Status:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Miscellaneous:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_ Siblings: \_\_\_\_\_\_\_\_\_\_\_\_

 Pets: Dogs\_\_\_\_\_\_\_\_ Cats\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** Diet Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Travel History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Females Only - OB/GYN History**

**Age of Menstruation:** \_\_\_\_\_\_\_\_ **Frequency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Duration:** \_\_\_\_\_Days \_\_\_\_\_Weeks \_\_\_\_Months

**Flow:** (please check) \_\_\_Light \_\_\_Regular \_\_\_Heavy **Pain Scale:** (please check) \_\_\_Mild \_\_\_Moderate \_\_\_Severe

**Premenstrual Symptoms:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Period:** (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Last: Pap:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mammogram:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Colonoscopy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contraceptives:** \_\_\_Yes \_\_\_No If Yes, What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age of Menopause:** \_\_\_\_\_\_\_\_ **# Child Births:** \_\_\_\_\_\_\_\_ ( Natural\_\_\_\_ C-Section(s)\_\_\_\_ ) **# of Miscarriages:** \_\_\_\_\_\_\_\_

H/O Fibroid\_\_\_\_\_\_\_\_\_\_ H/O Ovarian Cyst\_\_\_\_\_\_\_\_\_\_ H/O Endometriosis\_\_\_\_\_\_\_\_\_\_ H/O Cervical Cancer\_\_\_\_\_\_\_\_\_\_

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**General:**  **Urinary System - Female:** **Allergies:**

Change in appetite \_\_\_\_\_ Irregular periods \_\_\_\_\_ None \_\_\_\_\_

Change in weight \_\_\_\_\_ Menopausal \_\_\_\_\_ Hay fever /

Chills, fever, sweats \_\_\_\_\_ Hysterectomy \_\_\_\_\_ Environmental \_\_\_\_\_

 Vaginal discharge: \_\_\_\_\_ Food \_\_\_\_\_

**Head:** Difficulty urinating \_\_\_\_\_ \_\_\_Peanuts

Frequent headaches \_\_\_\_\_ Blood in urine \_\_\_\_\_ \_\_\_Soy

Recent trauma \_\_\_\_\_ \_\_\_Dairy

 **Muscle/Bones:** \_\_\_Eggs

**Eyes:** Pain \_\_\_\_\_ \_\_\_Wheat

Reading glasses \_\_\_\_\_ Weakness \_\_\_\_\_ \_\_\_Strawberries

Change in vision \_\_\_\_\_ Joint Swelling \_\_\_\_\_ \_\_\_Shellfish

Double vision \_\_\_\_\_ Backache \_\_\_\_\_ \_\_\_Other

 Degenerative Disease \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears/Nose/Throat/Mouth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of hearing \_\_\_\_\_ **Nervous System:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ringing in ears \_\_\_\_\_ Dizziness \_\_\_\_\_

Gum problems \_\_\_\_\_ Loss of consciousness \_\_\_\_\_

Bleeding \_\_\_\_\_ Seizures \_\_\_\_\_

Nose bleeds \_\_\_\_\_ Blackouts \_\_\_\_\_

Hoarseness \_\_\_\_\_ Nervous exhaustion \_\_\_\_\_

Difficulty swallowing \_\_\_\_\_ Numbness / Tingling \_\_\_\_\_

Morning cough \_\_\_\_\_ Strokes \_\_\_\_\_

Toothache \_\_\_\_\_ Vertigo \_\_\_\_\_ **Skin:**

 Skin cancer \_\_\_\_\_

**Respiratory:** Rash \_\_\_\_\_

Difficulty breathing \_\_\_\_\_ Non-healing lesion \_\_\_\_\_

Cough \_\_\_\_\_ Shortness of breath \_\_\_\_\_ **Emotional Status:**

Wheezing / Asthma \_\_\_\_\_ Nervousness \_\_\_\_\_

 Mood changes \_\_\_\_\_

**Heart:** Schizophrenia \_\_\_\_\_

Chest pain \_\_\_\_\_ Depression \_\_\_\_\_

Heart beats fast \_\_\_\_\_ Insomnia \_\_\_\_\_

Difficulty breathing

with activity \_\_\_\_\_ **Endocrine Glands:**

Elevated cholesterol \_\_\_\_\_ Thyroid \_\_\_\_\_

 Heat intolerance \_\_\_\_\_

**Digestive System:** Cold intolerance \_\_\_\_\_

Abdominal pain \_\_\_\_\_ Diabetes \_\_\_\_\_

Nausea \_\_\_\_\_ Excessive thirst \_\_\_\_\_

Vomiting \_\_\_\_\_ Excessive hunger \_\_\_\_\_

Bloating \_\_\_\_\_ Frequent urination \_\_\_\_\_

Diarrhea \_\_\_\_\_

Constipation \_\_\_\_\_ **Blood/Lymph System:**

Blood in stool \_\_\_\_\_ Anemia \_\_\_\_\_

Frequent belching \_\_\_\_\_ Easy bruising \_\_\_\_\_

Acid reflux \_\_\_\_\_ Easy bleeding \_\_\_\_\_

Heartburn \_\_\_\_\_ Aids / HIV \_\_\_\_\_

 Swollen glands \_\_\_\_\_

**Urinary System - Male:**

Penile discharge \_\_\_\_\_

Difficulty urinating \_\_\_\_\_

Blood in urine \_\_\_\_\_

Get up at night to urinate \_\_\_\_\_

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**Important Appointment Information**

It is our desire to operate in a manner that will best serve the needs of our patients. We ask that you help us by keeping in mind the following requests:

If you are more than **15 minutes** late for your appointment, you will need to reschedule if the schedule is full or if your appointment is at the end of the day.

If you will be unable to keep an appointment, please cancel as much BEFORE your scheduled time as possible. Our schedule is usually full and if you do not cancel, you are keeping a sick patient from having the opportunity to have the spot that you have scheduled.

**If you “ No-Show ” for three (3) appointments, you will be released from our practice.** If there is a change of address or phone number, it’s your responsibility to let us know so that you’ll receive a reminder call to avoid missing your appointment.

Medication refill requests should be called in to the pharmacy, not the office. Please call them at least 48 hours before you run out of medication. If there are no refills available, the pharmacy will fax the office for approval.

If you are requesting samples, please call the office to verify we have them in stock before coming to the office. We will not be able to provide all of your medications in samples. If available, samples are given to you when you are put on a new medication and then the prescription will need to be filled at your pharmacy.

If your prescribed medications require an authorization from your insurance company, it may take them several days to respond to us. We will send in the request to your insurance company and process the prescription as soon as we receive the approval from them.

If you have lab work or test ordered, we will contact you by phone or we will mail you the results when we receive them. **If you have not received your results within two weeks, please call the office.** Please make sure that any address or phone number changes made are updated with our office so that you do not miss a call from a provider, nurse, or staff.

If you have insurance, and you have a co-pay, it is payable at the time of your visit. This is required by our agreements with insurance companies.

When you come in for your Complete Physical Exam (CPE) and/or Well Woman Exam (WWE), **you must inform the nurse so we can be sure to bill it to your insurance company correctly**. If you need fasting labs and cannot do them at the time of your visit, you must return within 5 days to have the labs billed with your CPE or WWE. **Please note that if any other issues are discussed during your CPE / WWE, your insurance may not cover the office visit 100% and will require you to pay your portion of the office visit and you may receive a billing statement in the mail.**

Thank you for allowing us to show how much we care. We look forward to taking care of you and your family’s medical needs. We appreciate you!

Sincerely,

Dr. Shaun Kelehan and Staff

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Patient/ Guardian Signature Date

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**Patient’s Copy - Please Keep for Your Records!**

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We at Access Family Health take your medical confidentiality very seriously. We will not, and cannot, release information without your written authorization. This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available or you have an adult that helps coordinate your medical care. You should not designate your doctor.

By signing this authorization, I authorize Access Family Health, Inc. to use and/or disclose certain protected health information (PHI) about me to, or for, the party or parties listed below. As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

\_\_\_\_\_ I DO NOT authorize anyone to receive information regarding my medical care.

\_\_\_\_\_ I authorize my physician and the employees of this clinic to speak with: **Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Access Family Health, Inc. has acted in reliance upon this authorization.

I have been made aware of the **Notice of Privacy Practices** for **Access Family Health, Inc.**

**My Contact Information:**

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.** Any problems and/or questions concerning this form are to be referred to Access Family Health Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Access Family Health / Wellness Practices of America

1420 W Wells Branch Parkway, Suite 450, Pflugerville, TX 78660 Ph 512-806-0201 Fax 737-300-1420

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We are committed to providing you with the best possible care and we are pleased to discuss our financial policy at any time. Please ask us if you have any questions about our financial policy or your financial responsibility.

All new patients are asked to complete a *Patient Information Form* prior to being seen by the provider. We ask that you complete all of the information including your insurance information. We also ask to make a copy of a picture I.D. and your insurance card. These will remain a permanent part of your patient chart.

**Insurance Coverage and Patient Responsibility**

You are responsible for the payment of co-payment, co-insurance, non-covered services, or any patient responsible balance at the time of service. If you are covered by Medicare, Medicaid, BCBS or plan in which we participate as a provider, we will file your insurance claim. In the event your insurance company does not pay the full balance, we will notify you so that you may contact your insurance carrier or resolve your account. Please remember, payment responsibility rests with the patient, if there is no coverage for services performed.

All non-covered patients are expected to pay for services in full at the time services are rendered.

Please advise the office personnel of any changes in your insurance or any of your contact information or addresses.

Payment arrangements can be negotiated prior to services being rendered. Please ask for assistance, if required.

Should it ever become necessary to use the services of an outside collection agency to collect your account, you could be responsible for any costs incurred for that purpose.

**Assignment of Benefits**

I hereby authorize Access Family Health, Inc. to bill my insurance company directly for the services rendered. I understand that I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration, intermediaries, other providers or treatment or procedures, or intermediaries needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request for payment of medical benefits either to myself or to the party who accepts assignment benefits.

**Unaccompanied Minors**

The parents or guardians will be responsible for the full payment unless covered by a participating managed care plan. Authorization to treat an unaccompanied minor must be on file.

We thank you for carefully reading this financial policy. We trust that you understand its contents. Should you have any questions, please feel free to ask. Please sign below to indicate your understanding and acknowledgment of this policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Patient’s Name (Please print) Responsible Party’s Signature Date

Access Family Health / Wellness Practices of America

**Shaun Kelehan, MD**

**Austin Davidson, FNP-C Jayasree Krishnankutty, PA-C**

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**MEDICAL RECORDS RELEASE**

**Requesting records on:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 Patient’s Name Date of Birth

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City

 \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 State Zip Phone

**Authorizing to release:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Doctor, Hospital, or Clinic

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 Address City State Zip

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Fax

**Information needed:** \_\_\_\_Complete Medical Records **( including Growth Charts if 16 yrs of age and younger )**

 \_\_\_\_Consult Notes \_\_\_\_Labs \_\_\_\_Radiology / Imaging Reports

 \_\_\_\_EKG \_\_\_\_Operative Report \_\_\_\_Vaccine / Shot Records

 \_\_\_\_ER / Hospital / Discharge \_\_\_\_Pathology Report \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 Patient / Guardian Signature Date

**Release records to:**

 **Access Family Health / Wellness Practices of America**

 1420 W Wells Branch Parkway, Suite 450, Pflugerville, TX 78660 Ph 512-806-0201 Fax 737-300-1420

**Contract for ADD / ADHD and CONTROLLED SUBSTANCE Prescriptions**

 There is a **$5.00** charge when receiving a Controlled/ADD/ADHD written prescription UNLESS you have an office visit on the same day it’s written. **The fee must be paid by cash or check at the time the prescription is received… NO EXCEPTIONS!!**

 If your account is in bad debt, you will not be issued a prescription until your balance is paid and/or a payment plan is arranged and a payment is made on the account. All payments must be made on time in order to continue receiving the prescription.

 Please note that you are required to be seen by a provider every 3 months in order to continue receiving a controlled prescription. Although, with some patients a provider may ask them to return for follow up office visits much sooner. If you’ve not kept up with your routine 3 month office visits, a prescription will not be written until you have been seen by a provider.

 Remember that you cannot refill the prescription earlier than 30 days. Lost or stolen prescriptions are to be reported and in most cases require a police report. If you just left our office and realize the prescription has been written incorrectly, you must return it to the office of **Access Family Health & WPA** before a new one can be written.

 Controlled substance medications ( i.e., narcotics, tranquilizers, barbiturates, etc. ) can be beneficial for patients when prescribed and taken correctly. These medications are closely controlled by local, state, and federal conditions.

 Since my medical provider at **Access Family Health & WPA** may and/or will be prescribing such medication(s) for me and/or my child, I agree to the following conditions:

1. I will not request or accept any other controlled substance medication(s) from any other provider while I’m under the care of

**Access Family Health & WPA**.

 I understand the **only** exception is; if it’s prescribed to me while I’m admitted to the hospital or by other providers that I’m also a patient of. Please list other providers you are seeing outside this office and receiving controlled medication from.

 Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Not seeing any other provider

2. **Refills of controlled medications will:**

: Only be written during regular office hours with a 24 hour notice and will not be written at night, over the weekend, or during the holidays.

: NOT be written if I “run out early.” I am responsible for taking the medication(s) just as the dose is prescribed.

: Need to be filled at the same pharmacy. We will not refill to multiple pharmacies.

3. I understand that if I violate any of the above conditions, my controlled substance prescription(s) and/or treatment from **Access Family Health & WPA** will be terminated. If the violation involves obtaining controlled substances from another provider

as listed above or elsewhere, it’s my responsibility to inform this office immediately.

4. I’m now made aware that per law, regarding refills of controlled medications; patients MUST have an appointment and be seen by a provider every 90 days.

 I have read this contract thoroughly and my provider has or will fully explain to me the dangers of the medication(s) that may and/or will be prescribed, and by signing below I am agreeing to the terms and conditions of this contract.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **( If the patient is under the age of 18 )**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and agree to the terms listed above for (Please Print)

receiving my controlled medication prescription(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Parent/Guardian Date Provider’s Signature