Faith Family Wellness
207 Aberdeen Parkway Panama City, FL 32405
PH: (850) 788-3120 / FAX: (850) 788-3125

What is the reason for your visit today?
How did you hear about our office/who can we thank?

Patient Information			
Child's Legal Name	Birth Date	Age	Birth Gender ❑Male ❑Female
Name of Previous Provider:			Phone#
Mailing Address		City, State, Zip	
Current Grade Level and School:		Parents Email	
Special Needs:			
Extracurricular Activities			
Preferred Language			**Ethnicity:** Hispanic or Latino Not Hispanic or Latino
Race □African American □Asian □Caucasian □Hispanic □Native American □Native Hawaiian □Pacific Islander □Other _____□Prefer not to answer			

Guarantor/Responsible Party		
Legal Name of Responsible Party	**Birth Date**	**Relationship to Patient**

Medical Insurance (Please present ID & insurance card to the front desk)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Policy Holder Name	Insured Date of Birth	Patient Relationship □Self □Spouse □Dependent
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship □Self □Spouse □Dependent

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Faith Family Wellness or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian signature Date

Child's Legal Name: _____ **DOB:** _____

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PATIENT MEDICAL HISTORY

HEIGHT:	**WEIGHT:**
ALLERGIES (include medication, food latex and environmental allergies**)**	**No Known Allergies**□

Allergy to 1. _____ 2. _____ 3. _____

Severity/Reaction _____ _____ _____

CURRENT MEDICATION/SUPPLEMENTS (May provide detailed list or bring in bottles) **No Current Medication** □

Medication Name	Dose	Frequency
Preferred Pharmacy :		

HOSPITALIZATIONS/PROCEDURES/SURGERIES **NONE** □

_____ _____
Date Surgery Date Surgery

HEALTH MAINTENANCE CHECK RECENT TEST - Give month/year of last exam

Routine Physical: _____ Dental Exam: _____

Eye Exam: _____

Vaccination Status (please check): _____Up to date _____Delayed _____ Not Immunized

If delayed or not immunized explain:_____

PAST MEDICAL HISTORY

Check one for each box…..Yes or No

Condition	Y	N	Condition	Y	N	Condition	Y	N
ADHD			Fractures			Scoliosis		
Allergies			Intestinal Disorder			Seizure Disorder		
Asthma			Joint Disorder			Thyroid Disorder		
Acne			Kidney/Urinary Disease			**List others below:**		
Chicken Pox			Liver Disease					
Ear Infections			Meningitis					
Developmental Problems			Mental Illness					
Diabetes			Mononucleosis					
Eczema			Neurologic Disorder					
Eye Disease			Reflux					

Child's Legal Name: _____ **DOB:** _____

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Please provide any additional details regarding those condition(s) above where you marked "yes":

_____

Please list below any specialists you see/have seen, contact information if possible:

_____

_____

FAMILY HISTORY: Is there an history your family of? check all that apply
NO Significant Family History is Known □

	Mother	Father	Brother/ Sister	Grandmother *(Maternal)*	Grandmother *(Paternal)*	Grandfather *(Maternal)*	Grandfather *(Paternal)*
High Cholesterol							
Heart Attack							
Diabetes							
Prostate Cancer							
Kidney Cancer							
High Blood Pressure							
Kidney stones							
Other significant disease?							

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FINANCIAL AND CONSENT FOR TREATMENT AUTHORIZATION FORM

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the workflow in our office more efficient and practical. If you have any questions about these, please do not hesitate to ask one of our office staff members.

_____ **AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:** Consent for Treatment I consent freely and voluntarily to participate in the treatment that may be ordered by my health care provider. I understand that I may withdraw consent at any time. This may include but is not limited to Telemedicine services, outpatient treatment, and diagnostic procedures by the Faith Family Wellness as may be deemed necessary or advisable by my provider /or consultants. If I need additional treatments or procedures my consent will be obtained except in emergencies or unusual circumstances.

_____I authorize the release of any medical or demographic information to determine medical benefits or to facilitate payment for such services.

_____I understand that I am financially responsible to Faith Family Wellness and the clinic for any charges not covered by my healthcare benefits. It is my responsibility to notify the aforementioned provider of health coverage changes or additions in a timely fashion. I understand that if all or part of the balance is denied by insurance, I am responsible for the balance in full.

_____I understand that payment for services are due in full at the time of service unless other arrangements have been made in advance. At the time of service, I will pay for my co-pay or co-insurance portion and/or deductible.

_____ By Appointment Only: Walk-ins are not accepted. In order to have your child seen you must have a scheduled appointment.

PRESCRIPTIONS

_____ Prescription refills take 72 hours to process and complete. Please allow yourself at least three business days to get the medication filled. Please plan ahead if the prescription is due on a weekend or holiday and give us enough time to prepare the prescription.

_____ I understand that Faith Family Wellness may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand that my provider using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider to see this health information.

LATE POLICY /NO SHOW POLICY

_____ If you are running late for your appointment, please contact our office. We will determine whether or not your appointment will need to be rescheduled. If you arrive more than 15 minutes late to your scheduled Appointment time, we will make an effort to accommodate you. However, your appointment may be rescheduled.

_____ We may charge you a $25.00 “No Show” fee if you fail to cancel or reschedule your appointment at least 48 hours prior to your appointment date.

**** **This Pediatric Intake Form has been completed to the best of my ability.****

Signature of Parent/Guardian:_____ Date: ___/____/_____

Child’s Legal Name: _____ DOB: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS

I hereby authorize the release of my medical records. I understand that this information may include, if applicable, information relating to sexually transmitted diseases, HIV/AIDS, behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand that I have the right to inspect and obtain a copy of the information to be disclosed. I understand that reasonable fees for copying and releasing medical records, if any, may apply.

Unless revoked earlier, this authorization will expire one (1) year from the date of signature.

I understand that I may revoke this authorization at any time by submitting a written request. I understand that revocation will not apply to information that has already been released in reliance on this authorization.

I understand that this authorization to disclose health information is voluntary. I acknowledge that once this information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected under the HIPAA Privacy Rule.

Patient Name (Printed): _____

Patient or Parent/Guardian Signature: _____
Date: ___ / ___ / _____

Relationship to Patient (if applicable): _____
Patient Date of Birth: _____

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ACKNOWLEDGEMENT OF AVAILABILITY OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices:
You have the right to review Faith Family Wellness's Notice of Privacy Practices before deciding whether or not to sign this consent. A copy of the Notice is **available upon request**. The Notice describes how your protected health information may be used and disclosed for treatment, payment, and healthcare operations.

Purpose of Consent:
By signing this form, you consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as permitted by law.

Acknowledgement:
I acknowledge that I have been **informed of the availability** of this office's Notice of Privacy Practices and understand that I may request a copy at any time.

I understand that by signing this consent form, I am authorizing the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

_____ _____
Patient Signature or Representative Date

_____ _____
Relationship to Patient DOB

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, authorize **Faith Family Wellness** to release and/or discuss my medical information, including medical records or conditions, with the following individual(s)

NAME	Relationship to the patient

I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in reliance on this authorization.

Signature of Parent/Guardian:_____ Date: ___/____/_____

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AUTHORIZATION OF OTHER PERSONS FOR PATIENT TREATMENT AND TRANSPORT

I, _____, the parent/legal guardian of the below-named child:

Child's Name: _____Date of Birth: _____

Hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of **Faith Family Wellness**.

In addition, I give permission for the following person(s) to bring my child to Faith Family Wellness in my absence and to act on my behalf in authorizing medical care and treatment.

In the event of an emergency or other illness, I understand that the providers and staff of Faith Family Wellness may deliver any medical care deemed necessary regardless of the accompanying adult.

Unless notified otherwise in writing, Faith Family Wellness will assume that a child's biological and/or legal parents are legal guardians who have access to treatment options and medical information for the child, as permitted by law.

I (we) authorize the following individual(s) to bring my child/children in for treatment:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: ___ / ___ / _____