COHESIVE FAMILY MEDICINE

ANNUAL UPDATE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX ☐M ☐F	SSN

MAILING ADDRESS	APT. #	CITY	STATE	ZIP

EMAIL	PRIMARY CARE PHYSICIAN

LANGUAGE PREFERRED	RACE	ETHNICITY

CELL PHONE NUMBER	EMERGENCY CONTACT NAME	EMERGENCY CONTACT RELATIONSHIP

EMERGENCY CONTACT PHONE NUMBER	EMERGENCY CONTACT ADDRESS	GUARANTOR NAME

GUARANTOR RELATIONSHIP	GUARANTOR PHONE NUMBER	GUARANTOR ADDRESS

PREFERRED METHOD OF CONTACT? ☐ PHONE ☐ EMAIL ☐ MAIL

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO

MAY WE COMMUNICATE WITH YOU THROUGH THE PATIENT PORTAL? ☐ YES ☐ NO

REASON FOR VISIT _____
(List Symptoms)

ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?

☐ Employer ☐ Google ☐ Mailer ☐ Personal Referral ☐ Road/Building sign ☐ Social Media ☐ Website ☐ Existing Patient

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME	SSN	DOB

INSURANCE NAME	INSURANCE I.D. #

GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME	SSN	DOB

INSURANCE NAME	INSURANCE I.D. #

GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

Signature of Patient/Guardian _____ Date _____

*Patient Name*_____ *Date of Birth:*_____

Past Medical History Update: please check all that apply to you

○ ADHD	○ Diverticulitis	○ Liver Disease
○ Acne	○ Eating Disorder	○ Lupus (SLE)
○ AIDS/HIV	○ Eczema	○ Lymphedema
○ Anemia	○ Emphysema/Chronicbronchitis	○ Mental Health
○ Arthritis	○ Epilepsy	○ Mitral Valve Prolapse
○ Asthma	○ GERD	○ Multiple Sclerosis
○ Atrial Fibrillation	○ Gout	○ Neurologic Problem
○ Auto Immune Disorder	○ Heart Attack	○ Osteopenia/Osteoporosis
○ Anxiety	○ Herpes Simplex Virus Type 1 Type 2	○ Prostate (BPH)
○ Back pain	○ Headache/Migraine	○ Psoriasis
○ Benign positional vertigo	○ Heart Disease	○ SARS-COV-2 Date:
○ Blood Clot	○ Hepatitis A /B /C	○ Seasonal Allergies
○ Blood disorder	○ High cholesterol	○ Seizures
○ Cancer- Type:	○ Hormonal Therapy	○ Shingles (Herpes Zoster)
○ Cerebral Palsy	○ Human Papillomavirus(HPV)	○ Sleep apnea
○ Chron's Disease	○ Hypertension	○ Stroke
○ Congestive Heart Failure	○ Incontinence	○ Thyroid disorder
○ Chronic Obstructive Pulmonary Disease (COPD)	○ Influenza Year:	○ Tuberculosis
○ Depression	○ Insomnia	○ Ulcerative Colitis
○ Diabetes: Type 1 or Type 2	○ Kidney disease	○ Vertigo

*Patient Name*_____ *Date of Birth:*_____

Past Medical History Update: please check all that apply to you

__**Yes** __**No** __**UnkCovid-19 Vaccine:** Type: Pfizer, Moderna, J&J, Astra, Zeneca, Unknown Date(s):1st_____ 2nd_____
__**Yes** __**No** __**UnkInfluenza Vaccine: Type:** Quadrivalent, High Dose, LAIV, Nasal, Unknown Date: _____
__**Yes** __**No** __**UnkTetanus Vaccine:** Type: Type: Tdap, Td, DTaP, Unknown Date: _____
__**Yes** __**No** __**Unk Shingles Vaccine:** Type: Shingrix, Zostavax, Unknown Date(s): 1st_____ 2nd_____

Surgical History: ***Select the following that apply to you***

__Appendectomy	__Coronary Artery Bypass	__Hip: L / R	__Shoulder: L / R
__Breast Biopsy	__C-Section	__Hysterectomy	__Spine:
__Carpal Tunnel: L / R	__Foot: L / R	__Knee: L / R	__Thyroidectomy
__Cataract: L / R	__Gastric Bypass	__Mastectomy	__Tonsillectomy/ Adenoidectomy
__Cholecystectomy	__Hand: L / R	__Neuro:	__Tubal Ligation
__Colon/Rectal:	__Hernia:	__Prostatectomy	__Tympanostomy (PE Tube)
Other Surgeries:			

Family History: ***Select the following that apply to you***

Family	**Alive/Deceased**	**Medical Problems**
Mother		__Hypertension, __ Diabetes, __ Stroke, __Heart Disease, __Cancer __High Cholesterol, __ Thyroid Disease, __Myocardial Infraction, __Anxiety, __Depression, __Other:
Father		__Hypertension, __ Diabetes, __ Stroke, __Heart Disease, __Cancer __High Cholesterol, __ Thyroid Disease, __Myocardial Infraction, __Anxiety, __Depression, __Other:
Sibling(s)		__Hypertension, __ Diabetes, __ Stroke, __Heart Disease, __Cancer __High Cholesterol, __ Thyroid Disease, __Myocardial Infraction, __Anxiety, __Depression, __Other:
Other:		__Hypertension, __ Diabetes, __ Stroke, __Heart Disease, __Cancer __High Cholesterol, __ Thyroid Disease, __Myocardial Infraction, __Anxiety, __Depression, __Other:
__Family History is unknown		

Social History: ***Select the following that apply to you***

__Alcohol Usage Frequency: _____	__Tabacco Usage Type: __Vaping __Cigarettes __Cigars __Non-Smoking

COHESIVE
FAMILY MEDICINE

HIPAA Notice of Privacy Practices:

Patient Name:_____ Date of Birth:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, healthcare operations, and for purposes required by law. This notice also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you. This information relates to your past, present, or future physical and mental health condition and related healthcare services.

Uses and Disclosure or Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose and/or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to quality control, licensing, employee reviews and training of medical students.

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, public health issues, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement; coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures, under lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

COHESIVE
FAMILY MEDICINE

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care and for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and whom they apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If you wish, you then have the right to use another healthcare professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Consent to email, cellular telephone, or text usage for appointment reminders and other healthcare communications: I consent to receiving text messages, phone calls or emails reminding me of my appointments. **Note:** You may opt out of these communications at any time. The clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update your demographics and consents to the information that you just provided.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints – You may complain to the U.S. Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington D.C. 20201. If you believe your privacy practices have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was revised, published, and becomes effective on January 16, 2023. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Patient Name:_____ Today's Date:_____

Patient or Guardian Signature:_____ Pt. Date of Birth: _____

COHESIVE
FAMILY MEDICINE

Consent to Treatment, Release and Acknowledgement:

Patient Name:_____ Date of Birth: _____

Consent to Treatment:

I request those physicians and other healthcare professionals who care for me to perform routine exams, diagnostic procedures, hospital care and therapeutic treatments which in their judgement become necessary while I am a patient of Cohesive Family Medicine. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording, or filming when necessary, in the judgement of my physician to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I acknowledge that I have the right to request stopping of any recordings during and up until a reasonable time before the recording or film is used. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations. I authorize the practice to retain, preserve, and for scientific or educational purposes, dispose of any specimen or tissue taken from my body at their convenience. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes. In order to deliver quality healthcare, I understand that Cohesive Family Medicine, including its providers, develop and maintain health information which may include physician notes (both history and physical), medication reports, tests, tests results, and treatment plans. I concur that this health information is used for the following: care and treatment plans, billing statements, communication between interdisciplinary healthcare providers, and verification of services (by both third-party payers and government payers), for quality control by the physician practice.

Reason of Responsibility:

I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Cohesive Family Medicine will be my responsibility.

Consent to Appeal:

In the event that my insurance denies payment for any services rendered during this episode of care, I authorize the practice to file a grievance for payment on my behalf. I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to the practice filing a grievance on my behalf, I understand that I will not be able to file my own grievances concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent well be automatically rescinded, and I may file my own grievance if my healthcare provider does not file a grievance, or stops grieving my case.

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patients:

I request that payment of authorized Medicare benefits be made on my behalf to the practice for any services furnished to me by that provider of service. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

COHESIVE
FAMILY MEDICINE

Statement to Permit Payment of Medicaid Benefits to Provider and Physicians

I certify that the information given by me and in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or related Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician, the organization furnishing the services, the authorizing physician, or the organization to submit a claim to D.P.W. for payment.

Assignment of Insurance or Payor Benefits

I recognize that I am primarily liable for payments for services rendered; however, in the event that I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to Cohesive Family Medicine and any of its contracted healthcare providers. I authorize the practice and the appropriate healthcare providers to apply for benefits of services rendered during this admission for visit. I certify that the insurance or other coverage benefits information supplied by me is correct in accordance with applicable practice, provider, insurance policies or agreements. If my insurance carrier required pre-authorization for services I will receive, I understand that it is my responsibility to contact my personnel office and/or insurance carrier to obtain it. If I fail to do so, I could be liable for all or part of otherwise covered expenses.

Acknowledgement of Responsibility for Payment of Medical Bill

I guarantee payment of all charges incurred for services rendered by Cohesive Family Medicine for the patient's name on the opposite side of this page, less any amounts paid by any third-party payer. I guarantee the amount due for the non-insurable charges including co-payment, deductibles, etc., should my account be referred to an attorney for collections, I agree to pay reasonable attorney's fees and collection expenses.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a copy of the "HIPAA Notice of Privacy Practices". I understand that the information Cohesive Family Medicine acquires or creates about me, will only be disclosed to others for treatment, payment, and healthcare operations as set forth in the notice or as authorized by me in writing.

I certified that I have read this form and that I understand its contents.

Patient Name:_____ Today's Date:_____

Patient or Guardian Signature: _____ Pt. Date of Birth: _____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com

COHESIVE
FAMILY MEDICINE

Authorization to Disclose Health Information:

_____Yes, I authorize Cohesive Family Medicine to leave me voice messages regarding my protected health information as stated below.

_____ No, I do **NOT** want Cohesive Family Medicine to leave me voice messages.

Patient or Guardian Signature:_____ Date:_____

I hereby authorize Cohesive Family Medicine to release my health information as described in: Medical or Billing

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Protected health information may include info/documents regarding medical treatment of the patient including but not limited to diagnosis, procedures, treatment plans, appointments, and test results. As well as account and billing information, including but not limited to, account balances, payment arrangements, insurance claims status and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations govern the terms of the authorization. I understand that I have the right to revoke this authorization at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing.

Signature of Patient or Guardian:_____

Relationship of the Guardian:_____Date:_____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com

COHESIVE
FAMILY MEDICINE

State Law Regarding Narcotic Prescriptions:

House Bill 2931

Effective January 1, 2020

Patient Name:_____ Birth Date:____/ ____/____Today's Date: ____/____/____

Due to a new State of Oklahoma law, all narcotic medications MUST be sent to pharmacies in electronic form ONLY. Written narcotic scripts are no longer acceptable under this new law.

Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.**

It is your responsibility to update us on pharmacy changes at least 24 hours before medicines are prescribed. Once your prescription has been sent, it must be picked up at the pharmacy accordingly.

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone Number:_____

Confirm the above information is correct. As this is where you will be required to pick up your prescriptions.

Patient or Guardian Signature:_____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com

COHESIVE
FAMILY MEDICINE

Authorization for Release of Medical Record Information:

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Patient Phone Number:_____

Address:_____ City/State/Zip:_____

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ Facility Phone Number:_____

Facility Address:_____ City/State/Zip:_____

Facility Fax Number:_____

Dates and Type of Information to disclose:
□ 2 years prior from last date seen
□ Dates Other: _____
□ Specific Information Requested:
_____

The purpose of disclosure is:
□ Change of Insurance or Physician
□ Continuation of Care
□ Referral
□ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the dates on this authorization unless other dates specified.

I understand the information in my health record may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Cohesive Family Medicine
Address: 2508 N. Harrison City/State/Zip: Shawnee, OK 74804 □ Please mail records
Fax: 405-857-3122 Phone: 405-585-2030 ☒ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year form the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information being used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Guardian:_____ Date:_____

COHESIVE
FAMILY MEDICINE

Consent to Treat Minor Children:

I, _____, parent or legal guardian of _____,

born _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care and supervision of _____ and I am not reasonably available by telephone to give consent. (Person given permission to bring minor to the clinic)

This authorization is effective from _____ (Today's Date) to _____ (Date of your choice).

_____

Signature of Parent or Legal Guardian

_____ _____

Witness Signature **Witness Name (please print)**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address:_____

Telephone: Father's Name:_____ Father's Phone Number:_____

Mother's Name:_____ Mother's Phone Number:_____

Minor's Birthdate:_____ Last Tetanus:_____

Allergies to drugs or foods: _____

_____.

Special Medications, Blood Type, or Pertinent Information:

_____

_____

Preferred Hospital: _____