Faith Family
Healthcare Clinic
"We put the care back into healthcare"
(405) 418-0125 email: info@faithfamilyhealthcare.com

PATIENT INFORMATION

PATIENT INFORMATION

Full Name: ______________________ Nickname/AKA: __________
Last *First* *Middle*

Maiden Name: ______________ Date of Birth: __________
Month/Day/Complete Year

Address: ______________________ SS#: __________
______________________ Sex *(Male or Female)* : __________

City, State, Zip: ______________________

County: ______________ Primary Phone: ( ) __________

PO Box: ________ (Required if applicable) Alternate Phone: ( ) __________

City, State, Zip: ______________________

Preferred language: ______________ Preferred E-mail: __________
______________ __________

Marital Status: ______________ Race: __________
Single, Married, Divorced, Widowed, Partnered *Caucasian (white), Native American, African-American (black), Latin, Asian, other*

EMPLOYMENT

Employer: ______________________

Address: ______________________
______________________ Work Phone: ( ) __________

City, State, Zip: ______________________

EMERGENCY CONTACT

Only one (1) emergency contact is required

Name: ______________________ Primary Phone: ( ) __________

Address: ______________________ Alternate Phone: ( ) __________

City, State, Zip: ______________________ Work Phone: ( ) __________

Relationship: ______________ Employer Name: __________

Optional

Name: ______________________ Primary Phone: ( ) __________

Address: ______________________ Alternate Phone: ( ) __________

City, State, Zip: ______________________ Work Phone: ( ) __________

Relationship: ______________ Employer Name: __________

Patient Name: ______________________________ DOB: ______________

BILLING INFORMATION

ACCIDENTAL INJURY

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.) YES / NO Date: ______________

GUARANTOR INFORMATION *(This is the person responsible for the balance after insurance pays on the account.)*

***Parent/guardian** presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid. **If 18 or older,** you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.*

*******IF SELF DO NOT COMPLETE THIS SECTION*******

Guarantor Name: ______________________________ Guarantor SS#: ______________

(Last First Middle)

Relationship: ______________ Primary Phone: ( ) ______________

Address: ______________________________ Alternate Phone: ( ) ______________

City, State, Zip: ______________________________

PO Box: ______________ (Required if applicable)

City, State, Zip: ______________________________

Guarantor Employer: ______________________________ Work Phone: ______________

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: ______________________________

ID#: ______________________________ Effective Date: ______________

Patient Employment Status: ______________

(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION*******

Patient Relationship to Subscriber: ______________________________

Full Name: ______________________________ Sex: ________ Date of Birth: ______________

M or F

Address: ______________________________ SS#: ______________

City, State, Zip: ______________________________ Phone: ( ) ______________

Employer: ______________________________ Work Phone: ( ) ______________

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: ______________________________

ID#: ______________________________ Effective Date: ______________

Patient Employment Status: ______________

(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION*******

Patient Relationship to Subscriber: ______________________________

Full Name: ______________________________ Sex: ________ Date of Birth: ______________

M or F

Address: ______________________________ SS#: ______________

City, State, Zip: ______________________________ Phone: ( ) ______________

Employer: ______________________________ Work Phone: ( ) ______________

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and treatment. I hereby, authorize payment from my insurance company to the Ingrid Jackson MD LLC dba/ Faith Family Healthcare Clinic LLC for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: ______________________________ Date: ______________

Today's Date ________________ Patient Name ______________________________ DOB ______________

MEDICATIONS, ALLERGIES AND IMMUNIZATIONS

PRESCRIPTION MEDICATIONS -- List all medications you are presently taking.

	Name and Dose	*Prescribed by:*	*How Often*	*Date Started*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

NON-PRESCRIPTION MEDICATIONS -- List all non-prescription medications you are presently taking. Include over-the-counter medications, vitamins/supplements, herbals, and creams.

	Name and Dose	*How Often*	*Date Started*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT PHARMACY

	Name & Location	*Phone Number*
Preferred:		
Other:		

ALLERGIES -- List all allergies or unusual reactions you have to medications, foods, dyes, latex, and other agents.

	Allergy	*Reaction*
1		
2		
3		
4		

List any reactions to bug bites or stings.

____

____

ADULT IMMUNIZATIONS -- Check the box next to or list all immunizations received including the most recent date received.

		Date Received	*Others*	*Date Received*
☐	Tetanus			
☐	Flu			
☐	Pneumonia			
☐	HPV			
☐	Hepititis B			

Faith Family Healthcare Clinic

Patient Name ______________________________ DOB ________________

SURGICAL/SOCIAL/FAMILY HISTORY

HOSPITALIZATION & SURGICAL HISTORY -- *List all hospital admissions and operations you have had.*

	Reason for Hospitalization/Surgery	Year
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

SOCIAL HISTORY

YES NO — Do you currently smoke or use other tobacco products? If YES,
How many per day? . . . ____________________

YES NO — Have you smoked or used other tobacco products in the past? If YES,
How many per day? . . . ____________________rs since you last smoked? ____________

YES NO — Do you drink caffeinated beverages? If YES,
What type, how often, how mu____________________

YES NO — Do you drink alcohol? If YES,
What type, how often, how mu____________________

YES NO — Do you exercise regularly? If YES,
What type? . . . . ____________________
How often and how long?____________________

FAMILY MEDICAL HISTORY -- *Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.*

	Condition	Relationship	Age at onset
	High Blood Pressure		
	High Cholesterol		
	Heart Disease		
	Stroke		
	Migraines		
	Seizures/Convulsions		
	Diabetes		
	Bleeding/Blood-clotting Disorder		
	Allergies		
	Asthma		
	Thyroid Problems		
	Osteoporosis		
	Psychiatric Disorder/Mental Illness		
	Alzheimer's/Dementia		
	Cancer - type:		
	Other:		
	Other:		

Patient Name ____________________________ DOB ______________

Faith Family Healthcare Clinic

SURGICAL/SOCIAL/FAMILY HISTORY

SCREENINGS -- List the most recent date and doctor for the following screenings.

	Date	Doctor/Practice or Facility Name
Complete medical physical	______	______
Full panel of lab work	______	______
Cholesterol (lipid) screening	______	______
Chest X-ray	______	______
Treadmill stress test	______	______
Other heart tests	______	______
Colonoscopy	______	______
Mammogram	______	______
Bone density	______	______
Pap Smear	______	______

Please circle any existing medical problems:

High Blood Pressure   Diabetes   Cholestrol Problems   Reflux/Heartburn   Stroke   Anemia

Heart Disease (please cirlce if if applies: Valve, Coronary, Artery,or Irregular Rhythm)   Osteoarthritis   Osteoporosis

Menopause   Cancer (type ________________)   Allergies   Sinus Disease   Psoriasis   Rheumatoid Arthritis

Hypothyroidism   Liver Disease   Kidney Disease   Seizures   Migraines   Headaches   Diverticulosis

Irritable Bowel Syndrome   COPD/Asthma   Depression   Anxiety   Bipolar   Ecxema

ROS-Please circle any symptoms you have or have had recently:

Significant Weight Loss/Gain	Fever/Chills	Night Sweats
Excessive Fatigue	Insomnia	Loss of appetite
Headache	Blurred Vision	Glasses/Contacts
Double Vision	Ringing in ears	Hearing Loss
Sinus Drainage	Sore throat	Hoarseness
Chest Pain	Palpitations	Leg Swelling
Short of Breath	Cough/Sputum	Wheezing
Severe Heartburn	Difficulty swallowing	Nausea
Vomiting	Constipation	Diarrhea
Bloody Stools	Black stools	Abdominal Pain
Painful Urination	Blood in urine	Difficulty voiding
Breast Changes/Discharge	Menstrual changes	Hot flashes
Loss of Balance	Dizziness	Blackouts
Seizures	Prolonged Numbness	Sexual problems
Depression	Anxiety	Tremor
Rashes/Mole Changes	Joint pains/Swelling	Easy bruising

* Referenced as FFHC*

The following are the conditions for services provided by Ingrid W Jackson MD LLC dba/ Faith Family Healthcare Clinic LLC. and the various entities and providers affiliated with them each individually and collectively referred to as Ingrid Jackson MD dba Faith Family Healthcare Clinic LLC

____

I consent to all treatment given under the general and special instructions of the attending physician(s). Treatment may include, but is not limited to, diagnostic procedures, administration of anesthetics, use of prescribed medication, medical and physical therapy services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician or their designees.

If a health care worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker.

Assignment of Insurance Benefits and Third Party Claims

If the account is not paid at time of service, I hereby assign to IWJ /FFHC the proceeds from the following: That any medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health, accident or welfare benefits of any type or form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by or on behalf of a third party; and any other benefits due from the insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect, and that I have the right to make this assignment. In the event a claim for payment submitted by IWJ/ FFHC to my insurance carrier or plan administrator is denied, I hereby authorize IWJ/ FFHC to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy.

Financial Agreement

I understand that, if my insurance plan or policy requires a co-payment from me, I am required to pay that co-payment at the time service is rendered. I understand that, if I am self-funded, full payment i due at time of service. I understand that I am obligated to pay the patient account according the regular rates and terms of **Ingrid Jackson MD LLC dba / Faith Family Healthcare Clinic LLC**

***I also understand that I am responsible for all deductibles and balances owed on my account.**

***If you are in need medical care and have no insurance we have a sliding fee Discount Program.**

Medicare Patients

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to IWJ/ FFHC on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

Disclosure/Use of Health Information

I authorize **FFHC** to provide any health information related to this patient to the insurance company or other payor, for purposes of payment for the health care provided. I also authorize **FFHC** to provide health information to other physicians and healthcare facilities for continuing care. I further agree that **FFHC** can use the health information for operations such as peer review and outcomes analysis. I acknowledge that I have received a copy of the document Notice of Privacy Practices.

➤ ☐ **(Patient initial here to acknowledge that Privacy Notice was received.)**

I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as a part of and may be enforced under the practice name, provider name or as Ingrid W Jackson MD LLC dba/ Faith Family Healthcare Clinic LLC

Photographs

I understand that a facial photograph may be taken at the first visit and periodically thereafter for identification purposes only and that it will be part of my medical record and will be subject to all the protection that other personal health information receives.

Patient Name (PRINT)____ DOB ________________

Patient/Personal Representative Signature: ______________________________________ Date: ______________

PRINT Name and Relationship if Personal Representative: ____

DISCLOSURE OF MEDICAL INFORMATION

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
______________________	______________________
______________________	______________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

☐ Home: ______________________ ☐ Work: ______________________

☐ Cell phone: ______________________ ☐ Other: ______________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

Name of Person	Phone Number	Relationship to Patient
______________________	______________________	______________________
______________________	______________________	______________________

Messages: A request for return calls may be left on the following answering machine or voice mail *(check all that apply)*

☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail

(Check all that apply) ☐ At home ☐ At work ☐ On my cell phone ☐ I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: ______________________ Date: ____________

PRINT Name of Personal Representative: ______________________

Relationship of Representative to Patient: ______________________

FFHC Representative: ______________________ Date: ____________

Note: This restriction applies only to care provided by the Ingrid W Jackson MD LLC dba Faith Family Healthcare Clinic LLC practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or FFHC may terminate this restriction by completing the following.

The below signature is to be used if you would like to make the above information terminate on a certain date.

This agreement is terminated as of ____________ Signature ______________________ *(Date)* __________

Patient Full Name (PRINT) ______________________ DOB ____________

(405) 418-0125

FINANCIAL POLICY

Patient Full Name (PRINT) ____ DOB ________________________

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Ingrid W Jackson MD LLC dba /Faith Family Healthcare Clinic LLC and the various entities and providers affiliated with them each individually and collectively referred to as **INGRID JACKSON MD LLC dba/FAITH FAMILY HEALTHCARE CLINIC LLC**

Payment for Service: Our office will inform you of the amount due when you check out. This amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A **$35.00** service charge will be added on all checks returned to us for insufficient funds.

Non-appointment prescription refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment prescription: A $25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of medical forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: *There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities*

- *$..50per page* Not including xrays, photograph,image or pathology slide to such person or legal representative will be $5.00
- $.50 per page for all other pages
- Third party request $10.00 base fee and .50 per page plus postage or delivery fees
- Max Charge $200, plus postage or delivery fee

No-show Appointments: A fee of $40.00 for a follow up visits and $50.00 for New Patient Visit or Scheduled procedure will be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling the number listed above during normal business hours. If patient continues to miss appointments they risk being dismissed. ______ **initial here**

Payment for Services Provided by Faith Family Healthcare Clinic If you are having laboratory and/or diagnostic services , procedures, **injections, IV's, Pellets, Hyperbaric Therapy, weight loss program (if not covered by insurance)Must be paid in advance**

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at Faith Family Healthcare **1 (405)418-0125** to make payment arrangements. We will attempt to contact you by letter before your account i s forwarded to the collection office.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

Patient/Personal Representative Signature: ______________________________________ Date: ________________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

Representative: ____ Date: ________________

740 Signal Ridge Drive
Edmond, OK 73013
(405)418-0125

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT)________________________________ SS# ________________ DOB _______________

is requesting that the practice identified above release health information (check one) TO ☐ obtain ☐ FROM the person/company/agency/facility listed below.

Name, Position, or Department:	
Name of Organization:	
Address of Organization:	
Phone number of Organization:	

The information to be disclosed relates to service dates beginning ______________ and ending _______________

❑ Entire medical record	❑ Medication List	❑ Physical Therapy notes
❑ Demographic Information	❑ Immunizations	❑ Occupational Health Record
❑ History & Physical	❑ Test Results (lab, X-ray, etc.)	❑ Other: (specify)
❑ Medical/Surgical History	❑ Other Assessments	❑ Other: (specify)
❑ Physician Office Visits	❑ Discharge Summary	❑ Other: (specify)

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

❑ Request of Individual	❑ Change of Doctor	❑ Legal Investigation
❑ Referral to Specialist	❑ Insurance	❑ Other: (specify)
❑ Continuing Care	❑ Workers Comp	

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to Faith Family Healthcare Clinic as identified above .

Note:

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: ______________________________________ Date: _______________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

Released by: ____ Date: ______________
(Department Representative Name)