



MALE PATIENT INFORMATION

Patient Name: _____
Last First Middle "Nickname"

DOB: _____ Sex: _____ SSN: _____ Marital Status: _____ Drivers Lic #: _____

Ethnicity (circle one): African American American Indian Asian Primary Language: _____
Caucasian/White Hawaiian Hispanic/Latino Other

Address: _____
Street Apt # City State Zip Code County

Phone #: _____
Home Work Cell/Other Primary

Email Address: _____

Emergency Contact: _____
Name Relationship DOB Phone #

Insurance Information: Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address: _____

Policy Holder: _____
Last First Middle DOB

Address: _____ SAME?
Street Apt # City State Zip Code (check here)

Phone #: _____
Home Work Cell/Other

SSN: _____ Employer: _____

How did you hear about us?

- | | | |
|--|--|---|
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Yelp | <input type="checkbox"/> Web Search |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Health Grades | <input type="checkbox"/> Community Newsletter |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Radio | <input type="checkbox"/> Other: _____ |

PATIENT AGREEMENT

Thank you for selecting Kelliwood Family Practice (KFP) as your healthcare provider. Please take a moment to review our financial policy.

By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Kelliwood Family Practice HIPAA privacy notice at any time and understand that I may request a copy.

_____ Initials

KFP Medical Care Agreement

I authorize the physicians of KFP to administer medical treatment as deemed necessary. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. Although the doctors are participating providers with many insurance companies, it is the responsibility of the patient or guarantor to be familiar with his/her plan. We make every attempt to verify insurance eligibility and benefits prior to your visit; however, all insurance carriers state that verification is not a guarantee of payment. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to Kelliwood Family Practice. If we are unable to verify your benefits, payment will be due at the time of service. I understand that there will be a \$25.00 charge for appointments not cancelled 24 hours in advance.

_____ Initials

Medical Care Agreement

I authorize the physicians of KFP to instruct their Physician Assistant/Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.

I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervisions/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of KFP if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduler with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

_____ Initials

Patient Name (please print): _____

DOB: _____

Patient Signature: _____

Date: _____

Kelliwood Family Practice Fees & Services

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Genesis Laboratories (GL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by GL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a \$35 fee for bounced checks and an additional \$20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

\$10 Controlled substance prescriptions without an appointment

\$25 School forms

\$35 Disability forms

\$45 FMLA

\$25 Physician dictated letter

\$25 Prior authorizations

\$25+ for extensive medical records

Thank you for your cooperation.

Patient Name (please print): _____

DOB: _____

Patient Signature: _____

Date: _____

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Cell Phone#: _____ Email: _____

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of your lab results and/or physician instructions and to discuss billing issues pertaining to your healthcare.

Please check the sections that apply, then sign at the bottom of the page:

_____ **I do not give KFP permission** to release my information to anyone other than myself.

or

_____ **I give KFP permission** to release my information with the following emergency contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please indicate how you would like to be notified with the information. (Check all that apply)

_____ Home phone # _____

_____ Cell Phone # _____

If you have an answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?

_____ YES _____ NO

_____ Work Phone # _____

If you have an answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?

_____ YES _____ NO

Signature: _____ Date: _____

(A signature is required for this form to be considered valid)

MALE



Kelliwood Family Practice



Kelliwood Family Practice

HEALTH HISTORY FORM

Today's Date: _____

Name: _____ DOB: _____

Previous Primary Care Physician: _____

Other physicians (specialists) involved in your care: _____

Preferred pharmacy: _____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Alcoholism	Yes	No
Allergies	Yes	No
Anemia	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Back pain	Yes	No
Blood clots	Yes	No
If yes: where? _____		
Cancer	Yes	No
If yes: what type? _____		
Chrohn's / Ulcerative colitis	Yes	No
Depression	Yes	No
Diabetes	Yes	No
If yes: what type? 1 _____ 2 _____		
Emphysema / Lung disease	Yes	No
Endometriosis	Yes	No
Eye disease	Yes	No
If yes: what type? _____		
Fractures	Yes	No
If yes: what type? (A, B, C) _____		
Hernia	Yes	No
If yes: what type? _____		
High blood pressure	Yes	No

High Cholesterol	Yes	No
HIV	Yes	No
HPV infection	Yes	No
Incontinence	Yes	No
Insomnia	Yes	No
Kidney disease	Yes	No
Kidney stones	Yes	No
Osteoporosis	Yes	No
PCOS	Yes	No
Stomach Reflux	Yes	No
Seizures	Yes	No
Sleep apnea	Yes	No
STDs	Yes	No
Stroke	Yes	No
Stomach ulcers	Yes	No
Thyroid disease	Yes	No
If yes: what type? _____		
Tuberculosis	Yes	No
Urinary tract infections	Yes	No

Other medical history? _____

SURGICAL HISTORY:

Have you had any of the following?

Abdominal surgery	Yes	No
Appendectomy	Yes	No
Brain surgery	Yes	No
Back surgery	Yes	No
If yes: what type? _____		
Bladder surgery	Yes	No
Breast biopsy	Yes	No
If yes: location	Right	Left
Breast surgery	Yes	No
If yes: location	Right	Left
C-Section	Yes	No
Cosmetic surgery	Yes	No
If yes: what type? _____		

Eye surgery	Yes	No
If yes: what type? _____		
Gallbladder removal	Yes	No
Heart surgery	Yes	No
If yes: what type? _____		
Hysterectomy	Yes	No
Hernia repair	Yes	No
If yes: what type? _____		
Ovarian Cyst removal	Yes	No
If yes: location	Right	Left
Thyroid surgery	Yes	No
If yes: what type? _____		
Tubal ligation	Yes	No
Other surgical history? _____		

SOCIAL HISTORY:

Marital status: _____
Occupation: _____
Current tobacco use Yes No
 Previously but quit: (date) _____
 Packs per day _____
 Years of use: _____ yrs
 Type: Cigarettes Cigars Chewing
 Dip Pipe E-cigarettes
Exposure to second hand smoke? Yes No
Alcohol use Yes No
 If yes: # drinks / week _____

Type of alcohol _____
Are you or others concerned
about your drinking? Yes No
Drug use Yes No
 If yes: type _____
Do you practice any religion Yes No
 If yes, which one? _____
Do you exercise? Yes No
How often? _____ times/week
What type of exercise? _____

HEALTH MAINTENANCE:

If you've had any of the following please specify date last performed:

Prostate Exam No Yes: when? ____/____/____
PSA ____/____/____
Colonoscopy ____/____/____
- Result: Normal Polyps Diverticula Hemorrhoids Other: _____
Bone density scan ____/____/____
- Result: Normal Osteopenia Osteoporosis
CT for lung cancer screening ____/____/____
Dental exam ____/____/____
Eye exam ____/____/____
Tetanus shot ____/____/____
HPV series (3) ____/____/____
Flu shot ____/____/____
Pneumonia shot: Pneumovax ____/____/____
Prevnar 13 ____/____/____
Shingles vaccine ____/____/____
Hepatitis A vaccine ____/____/____
Hepatitis B vaccine series ____/____/____
Meningitis vaccine ____/____/____