Whitefoord, Inc.
Uniting Community through Health and Education

ADULT PATIENT CONSENT FORM

Thank you for allowing Whitefoord Family Medical Center to serve you. Please complete this consent form and provide proper documentation of insurance in order to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive comprehensive health services at Whitefoord Family Medical Center. I further authorize any health professional working for Whitefoord Family Medical Center to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Whitefoord Family Medical Center personnel under the instructions, orders or direction of such physician(s).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of all of my insurance benefits, sick benefits, Medicare benefits and injury benefits due because of liability of a third-party, payable by any party or organization directly to Whitefoord Family Medical Center or any Whitefoord Family Medical Center-based physician, unless the account for the facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I understand that I am responsible for any charges not covered by my insurance company.

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Whitefoord Family Medical Center. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Whitefoord Family Medical Center visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Whitefoord Family Medical Center's Notice of Privacy Practices that provides information about how the Whitefoord Family Medical Center may use and disclose my protected health information.

I have read and understand the above information and give permission for my care as described. *I understand that I have the right to OPT-OUT of any medical testing or treatment.* I also understand that I may obtain further information regarding the health services offered by Whitefoord Family Medical Center by contacting (404) 588-0101.

_____

Patient Name

_____ _____/_____/_____

Patient/Legal Representative Signature **Date**

_____ _____/_____/_____

Witness Signature **Date**

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ADULT PATIENT INFORMATION FORM

PRESENT HEALTH CONCERN/REASON FOR VISIT: _____

PATIENT INFORMATION (All fields required)

Last Name: _____ **First Name:** _____

Street Address: _____ **County:**_____ **City:**_____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Current Primary Care Provider (PCP): _____ ☐ I don't have one but would like to make Whitefoord my PCP

Date of Birth (mm/dd/yyyy): _____ **Sex:** ☐ Male ☐ Female ☐ Transgender (M-to-F) ☐ Transgender (F-to-M)

Marital Status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated ☐ Unknown

Employer Name (if applicable): _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Emergency Contact Name: _____ **Emergency Contact Relation to patient:** _____

Emergency Contact Address: _____

Emergency Contact Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Email: _____ **Race:** ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White

Race Cont. : ☐ Hispanic ☐ More than one race ☐ Other: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Primary Language: _____ **Do you require a translator?** ☐ Yes ☐ No **Do you have limited English Proficiency?** ☐ Yes ☐ No

Present Housing Situation (check any that apply): ☐ Migrant ☐ Seasonal ☐ Homeless ☐ Public Housing **Are you a Veteran?** ☐ Yes ☐ No

Does this patient have an advanced directive (legal document stating patient's wishes regarding medical treatment if no longer able to communicate to doctor)? ☐ Yes ☐ No

How did you hear about Whitefoord? Please Specify: _____

FINANCIAL AND INSURANCE INFORMATION (All fields required)

Financially Responsible Party (financially responsible for payment or primary insurance holder): ☐ Self ☐ Other

If other, Name: _____ Relationship to patient: _____

What is the financially responsible party's number of dependents?: _____

What is the financially responsible party's estimated income? _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐Yearly

Are you covered by medical insurance?: ☐ Yes ☐ No If yes, what type of insurance?: ☐ Medicaid ☐ Private ☐ Other: _____

If Medicaid: Medicaid ID #: _____

If Private Insurance: Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #: _____

Do you have dental insurance? ☐ Yes ☐ No *If yes, please fill out the following:*

Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #:_____

Preferred Pharmacy Name: _____ **Preferred Pharmacy Phone Number:** _____

Preferred Pharmacy Address: _____

Medical History

GENERAL HEALTH, HOSPITALIZATION AND SURGERY

How often do you engage in physical activity?: ☐ Daily ☐ More than once a week ☐ Weekly ☐ Monthly ☐ Never

Do you have any allergies (food, medications, anesthetic, latex, other)? : ☐ Yes ☐ No

If yes, list allergies: _____

Do you have an Epi-Pen? ☐ Yes ☐ No

Has you accessed, been treated or received care in an Emergency Room in the past 6 months? ☐ **Yes** ☐ **No**

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No

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If yes, Year(s): _____ **Reason(s):** _____

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?:

Condition	Yes	No	Age of Onset	Family Member with Condition (list member)?
Neurological (Brain) **and Nerve disorders** (ex. Migraines, Seizures)				
Eye disorders				
Ear/Nose/Throat disorders				
Oral/Dental disorders				
Endocrine/gland disease/autoimmune disorders (ex. Diabetes, Hyperthyroidism)				
Lung Disease/Problems (ex. Asthma, Pneumonia)				
Heart Disease/ Problems (ex. Hypertension)				
Gastro-Intestinal disorders (ex. Gallstones, Ulcers)				
Urinary Tract Disease/Problems (ex. Kidney stone, over active bladder)				
Reproductive disorders (ex. HIV, STDs)				
Genital disorders				
Skin disorders (ex. Psoriasis, Eczema)				
Blood /Lymph disorders (ex. Anemia)				
Allergy/Immunology disorders				
Behavioral Health problems/Mental Illness (ex. Depression, Eating Disorder)				
Musculoskeletal/Joint disorders (ex. Scoliosis)				
Developmental Disorders (ex. Autism)				
School/Psycho-social problems (ex. ADD)				
Cancer/Malignancy				
Others (ex. TB, Hepatitis, Chicken Pox)				

BEHAVIORAL HEALTH:

Would you like to enroll in behavioral health services? ☐ Yes ☐ No
Have you ever experienced sexual or physical abuse? ☐ Yes ☐ No

DENTAL HEALTH:

Would you like to enroll in dental services? ☐ Yes ☐ No
Have you had a dental cleaning within the last 6 months? ☐ Yes ☐ No
Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No

LIST OF MEDICATIONS (if you are currently on any medications, please list them below):

1.	**4.**	**7.**
2.	**5.**	**8.**
3.	**6.**	**9.**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fill this page out if you would like to release your healthcare information to Whitefoord Family Medical Center

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

Social Security Number: _____

I request and authorize _____ **to release healthcare information of the patient named above to:**

Whitefoord Family Medical Center
30 Warren Street
Atlanta, GA 30317
Phone: (404) 373-2282 Fax: (404) 373-2926

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:
_____

☐ All healthcare information relating to the above OR

- ☐ Records only
- ☐ Lab results and X-ray/Radiology Reports
- ☐ Consultant Notes
- ☐ Other: _____

I authorize the release of STD and HIV/AIDS results whether negative or positive. I understand that Whitefoord Family Medical Center will be notified that I must give specific written permission before disclosure of these test results to anyone. ☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Whitefoord Family Medical Center. ☐ Yes ☐ No

I understand that I have the right to withdraw this consent at any time upon written notice to the Whitefoord Family Medical Center Director.

_____ _____/_____/_____
Patient Signature **Date**

_____ _____/_____/_____
Parent/Guardian Signature **Date**

This Authorization Expires 180 Days After It Is Signed