1 NP Inc., dba Farwell Family Healthcare
301 Third St, Suite B, P.O. Box 245
Farwell, Texas 79325
PH 806-481-7000
Fax 806-481-1006

REGISTRATION FORM

PATIENT INFORMATION

Date:_____ Home Phone: _____ Cell Phone: _____

Legal Name:_____ SS/Patient # _____
Last Name First Name Middle Initial

Preferred Name: _____

Physical Address:_____ Mailing Address:_____

City _____ State _____ Zip _____

Sex: □ Male □ Female Age _____ Birthdate _____ □Minor □Single □Married □ Partnered for _____ years
□Separated □Divorced □Widowed

□Caucasian □African American □Hispanic □Asian □Other

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

In case of emergency, who should be notifed? _____ #:_____ Relation?_____

Mothers Maiden Name: _____

Who may we thank for referring you?_____

PRIMARY INSURANCE

Subscriber Name _____ Relationship to Patient _____
Last Name First Name Middle Initial

Birthdate _____ Soc. Sec. # _____

Address_____ City _____ Zip_____
(if different from patient's)

Employed By _____ Occupation_____

Bus. Address _____ Bus. Phone_____

Insurance Company_____

Phone# Group # _____ Subscriber #_____

ADDITONAL INSURANCE

Is patient covered by additonal insurance? □ Yes □ No

Subscriber Name _____ Relationship to Patient _____
Last Name First Name Middle Initial

Birthdate _____ Soc. Sec. # _____

Address_____ City _____ Zip_____
(if different from patient's)

Employed By _____ Occupation_____

Bus. Address _____ Bus. Phone_____

Insurance Company_____

Phone# Group # _____ Subscriber #_____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependant(s) have insurance coverage with_____ Name of Insurance Company(ies) and authorize payment directly to attending physician/nurse practitioner of all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependants. The above-named physician/nurse practitioner my use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. This content will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Person Responsible Date

_____

Please print name of Patient, Parent, Guardian, or Person Responsible Relationship to Patient

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FAMILY MEDICAL HISTORY

__I don't know the medical history of my biological parents or other family memebers (Go to next section)	Mother: ___ Alive Age: ____ Deceased at age: _____ because of _____	Father: ___Alive Age: ____ Deceased at age: _____ because of _____	Number of Living brothers/sisters_____ Number of deceased brothers/sisters_____ Cause(s)_____

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply:

◊ Stroke	◊ Heart trouble	◊ Kyphosis
◊ Diabetes	◊ Back problems	◊ Arthritis
◊ Lung disease	◊ Cancer	◊ None of these
◊ High Blood Pressure	◊ Osteoporosis	◊ Don't know
	◊ Scoliosis	◊ Other _____

PAST MEDICAL HISTORY

What surgeries have you had?

◊ Tonsillecotomy/Adenoidectomy	Date: _____
◊ Appendectomy	Date: _____
◊ Gallbladder	Date: _____
◊ Hysterectomy	Date: _____
◊ Diabetic	Date: _____
◊ Other	Date: _____

1._____	Date: _____
2._____	Date: _____
3._____	Date: _____
4._____	Date: _____
5._____	Date: _____
6._____	Date: _____
7._____	Date: _____

Allergies (food, medication, ect.)

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Over the Counter/Prescription Medications and Dosage

1._____
2._____
3._____
4._____
5._____
6._____
7._____

Habits:

_____

_____

SOCIAL HISTORY

Smoking

Do you now or have you ever smoked?
◊ Yes ◊ No
If YES, please complete the following:
I smoke ___packs per day and I have smokes for ___years.
OR
I did smoke___packs per day for ___ years, but I quit smoking___years ago.
Do you use any smokeless tobacco products?
◊ Yes ◊ No

Alcohol

Do you drink:
Beer? ◊ Yes ◊ No
Wine? ◊ Yes ◊ No
"Hard" drinks? ◊ Yes ◊ No
Frequency of drinking:
◊Never ◊Rarely
◊Daily ◊Socially (how often____)

Do you have a history of heavy drinking?
◊ Yes ◊ No

Coffee

Do you drink coffee?
◊ Yes ◊ No
If YES, how many cups per day?
_____

Soft Drinks

Do you drink soft drinks?
◊ Yes ◊ No
If YES, how many 12 oz. cans per day? _____

Education

Check the highest level completed:
◊ Grammer School
◊ High School
◊ College
◊ Post-graduate

Drugs

Do you use any recreational drugs? ◊ Yes ◊ No
Have you ever used needles to inject drugs? ◊ Yes ◊ No

Please list current problems or any other relevant medical or past history:_____

_____

_____

_____

_____

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HEALTH HISTORY

(CONFIDENTIAL)

Name:_____ **Today's Date:**_____

Date of last physical examination:_____

SYMPTOMS (Check symptoms you currently have or have had in the past year.)

General

◊ Chills
◊ Depression
◊ Dizziness
◊ Fainting
◊ Fever
◊ Forgetfulness
◊ Headache
◊ Loss of sleep
◊ Loss of weight
◊ Nervousness
◊ Numbness
◊ Sweats

Gastrointestinal

◊ Appetite poor
◊ Bloating
◊ Bowel changes
◊ Constipation
◊ Diarrhea
◊ Excessive hunger
◊ Excessive thirst
◊ Gas
◊ Hemorrhoids
◊ Indigestion
◊ Nausea
◊ Rectal bleeding
◊ Stomach pain
◊ Vomiting
◊ Vomiting blood

Eye, Ears, Nose, Throat

◊ Bleeding gums
◊ Blurred vision
◊ Crossed eyes
◊ Difficulty swallowing
◊ Double vision
◊ Earache
◊ Ear discharge
◊ Hay fever
◊ Hoarseness
◊ Loss of hearing
◊ Nosebleeds
◊ Persistent cough
◊ Ringing in ears
◊ Sinus problems
◊ Vision-Flashes
◊ Vision-Halos

Men Only

◊ Breast lump
◊ Erection difficutlies
◊ Lump in testicals
◊ Penis discharge
◊ Sore on penis
◊ Other

Women Only

◊ Abnormal Pap smear
◊ Bleeding between periods
◊ Breast lump
◊ Hot flashes
◊ Nipple discharge
◊ Painful intercourse
◊ Vaginal discharge
◊ Other

Date of last:
Menstrual period _____

Date of last:
Pap Smear _____

Have you had a mammogram?
◊ Yes ◊ No

Are you pregnant?
◊ Yes ◊ No

Number of children: _____.

Muscle/Joint/Bone

◊ Arms ◊ Hips
◊ Back ◊ Legs
◊ Feet ◊ Neck
◊ Hands

Genito-Urinary

◊ Blood in urine
◊ Frequent urination
◊ Lack of bladder control
◊ Painful urination

Cardiovascular

◊ Chest pain
◊ High blood pressure
◊ Low blood pressure
◊ Poor circulation
◊ Rapid heart beat
◊ Swelling of ankles
◊ Varicose veins

Skin

◊ Bruise easily
◊ Hives
◊ Itching
◊ Change in moles
◊ Rash
◊ Scars
◊ Sore

Conditions (Check conditions you have or have had in the past.)

◊ AIDS
◊ Alcholism
◊ Anemia
◊ Anorexia
◊ Appendicitis
◊ Arthritis
◊ Asthma
◊ Bleeding disorders
◊ Breast lump
◊ Bronchitis
◊ Bulimia
◊ Cancer
◊ Cataracts
◊ Chemical Dependency
◊ Chicken Pox
◊ Diabetes
◊ Emphysema
◊ Epilepsy
◊ Glaucoma
◊ Goiter
◊ Gonorrhea
◊ Gout
◊ Heart Disease
◊ Hepatitis
◊ Hernia
◊ Herpes
◊ HIV Positive
◊ High Cholesterol
◊ Kidney Disease
◊ Liver Disease
◊ Measles
◊ Migraine Headache
◊ Miscarriage
◊ Mononucleosis
◊ Multiple Sclerosis
◊ Mumps
◊ Pacemaker
◊ Pneumonia
◊ Polio
◊ Prostate Problem
◊ Psychiatric Care
◊ Rheumatic Fever
◊ Scarlet Fever
◊ Stroke
◊ Suicide Attempt
◊ Thyroid Problems
◊ Tonsillitis
◊ Tuberculosis
◊ Typhoid Fever
◊ Ulcers
◊ Vaginal Infections
◊ Venereal Disease

1 NP Inc. dba
Farwell Family Healthcare
Consent to Treatment

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) hereby consent to medical treatment, including radiological and laboratory procedures, to be performed by the nurse practitioner and staff of Farwell Family Healthcare. This consent is valid from this date forward.

Release of Information: The Farwell Family Healthcare and/or any nurse practitioner treating the patient may disclose to any person or corporation which is or may be liable under a contract to the clinic and/or physician or to the patient or to a family member of the patient for all or part of the clinic and/or physician or nurse practitioner charges, including, but not limited to clinic or medical service companies, insurance companies, workman's compensation carriers, welfare funds, or the patients employer.

Financial Agreement: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

Medicare and/or Medicaid Certification: The undersigned certifies that he/she has read the foregoing, and is the patient or duly authorized by the patient as patient's general agent to execute the above and accept its terms.

"I assign payment for the unpaid charges for certain medical treatment furnished by the nurse practitioner and staff of the Farwell Family Healthcare and by attending physicians for whom the clinic is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time of services rendered."

"I certify that the information given by me in applying for payment under Title XVIII and /or Title XIX for the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf."

_____ _____
Patients Signature Date

_____ _____ _____
Witness Signature Relationship

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PATIENT CONSENT AND ACKNOWLEGDMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as a part of the provision of healthcare services, Farwell Family Healthcare creates and maintains health records and other information describing among other things, my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care of treatment.

I have been provided with a notice of privacy practices that provide a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserve the right to change the notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me of the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records whether written or oral or in electronic format are confidential and cannot be disclosed for any reason outside of treatment, payment and health care operations without my prior written authorization.
2. A photocopy of fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purpose of treatment, payment and health care operations, be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclosure of my protected health information; and agree to terminate any restriction in writing on the use and disclosure of my protected health information which I have been previously agreed upon.

_____ _____
Patients Name Printed Date of Birth

_____ _____
Patients Signature (for Guardian of a Minor) Patients Social Security Number (ID purposes only)

_____ _____
Witness (optional) Date

If you wish for information to be released and/or discussed with a third party of your choice, please complete the following:

I, _____, authorize Farwell Family Healthcare, Lacey Meeks FNP-BC, and/or Dr. Craig Barker and staff to release information regarding my health and medical treatment to the person(s) listed below.

_____	_____	_____
Name	Relationship to patient	Phone Number
_____	_____	_____
Name	Relationship to patient	Phone Number

_____

Patient Signature Date

Can appointment notifications be sent by:

__ e-mail __Yes __No e-mail address _____

__Text Notifications ___ Yes ___No

__ Voice Notifications ___ Yes ___ No

Can we contact you by cell phone? ___ yes ___ no If yes please enter a cell phone number.

(___)-____-_____

Can we contact you at work? ____ yes ____no If yes please enter a work phone number.

(___)-____-_____

Can we leave a message for you at ___ work, ___ home, ____ or cell phone.

1 NP Inc. dba
FARWELL FAMILY HEALTHCARE

P.O. BOX 245, 301 THIRD ST. SUITE B
FARWELL, TEXAS 79325
PHONE: (806)481-7000
FAX: (806)481-1006

NOTICE TO PATIENTS

This is to inform you that you will be seen and treated by a Nurse Practitioner. A Nurse Practitioner is a skilled health provider who works with physicians to provide needed services, but is not a doctor. Please sign this form if you and/or your children consent to be seen and treated by a nurse practitioner.

Patient Name _____ Date of Birth _____

Signature _____ Date _____

AVISO DE INFORMACION

Este aviso de informacion es Enfermera Practicante. El Enfermera Practicante son personas que an estudiado y enrenado para poder proporcianar los servicios necesitados, pero no son doctores. Por favor firme este consentimiento si permite que el Enfermera Practicante lo trate a used o asus ninos.

Nombre Del Paciente _____ Fecha De Nacimiento _____

Firma _____ Fecha _____

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I, _____, understand that the 1 NP Inc., dba Farwell Family Healthcare does not treat or file claims for Workman's Compensation related treatment.

Please be advised that 1 NP Inc., dba Farwell Family Healthcare has the right to disclose any information regarding your treatment at our facility to an insurance company or your employer that suspect treatment for workman's compensation.

_____ _____
Signature Date

_____
Print name here

I, _____, (patient name) understand that 1 NP Inc., dba Farwell Family Healthcare does not treat any automobile accident patients.

Please be advised that 1 NP Inc., dba Farwell Family Healthcare reserves the right to refuse patients involved in automobile accidents.

_____ _____
Signature Date

_____
Printed Name

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Social Media and Texting

I, _____, understand that any and all medical question need to be addressed at Farwell Family Healthcare and not on social media or through electronic devices.

_____ _____
Signature Date

_____
Print name here

Medication Refills

I, _____, understand that I need to call my pharmacy for any and all medication refills. Once Farwell Family Healthcare receives the refill request, please give Farwell Family Healthcare 24-48 business hours to respond.

Farwell Family Healthcare

P: 806-481-7000 | F: 806-481-1006

Lacey Meeks, MSN,ACNP-BC,FNP-BC

Cancellation/No Show Policy for office appointments/ injections

*Cancellation/No show policy for office appointments

We understand that there are times when you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel and we are unable to schedule **you** due to a seemingly full schedule.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a $25 fee. This will not be covered by your insurance and must be paid prior to further treatment.

Patient Name (printed) _____

Patient Signature _____

Date Signed _____

Date of Birth _____