J.C. HEALTHCARE & Associates

We bring care and healing to you.

Patient Agreement Form

1. I _____ (patient name) give permission for **J.C. Healthcare & Associates, LLC** to give me medical treatment.

2. I understand that J.C. Healthcare & Associates will **not** submit a claim for insurance benefits to pay for the care I receive.

   I understand that:
   - All services I receive must be paid by cash, debit or credit card in full at time of service.
   - It is my responsibility that if I have insurance, I will contact my insurance company to discuss reimbursement of services paid for.
   - I must pay for the cost of these services if even if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my healthcare provider.
   - I have the right to request to be seen or referred to another healthcare provider such as a physician or nurse practitioner.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian Signature (for minors under 18) Date

_____ _____

Print name Date

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New Patient Registration

PLEASE PRINT

Last Name of Patient	First Name	MI	M F	Age

Address	City	State	Zip

Home Phone ( )	Cell Phone ( )	Date of Birth	Social Security No.

Your Email address:	

Responsible Party or Insurance Policy Holder

Last Name	First Name	MI	Male Female

Address	City	State	Zip

Home Phone ( )	Cell Phone ( )	Date of Birth	Social Security No.

Medical Insurance Company Information

Name of Primary Insurance Company	Name of Policy Holder

SS#	ID#	Group#

Name of Secondary Insurance Company	Name of Policy Holder

SS#	ID#	Group#

Name of Primary Care Physician	Phone ( )

Meaningful Use (required by law): Please circle

Race: American Indian or Alaskan Native Asian, Native Hawaiian, or other Pacific Islander Black or African American, White, Hispanic, other race, other Pacific Islander, Unreported/refuse to report	**Ethnicity:** Hispanic, Non-Hispanic, Refuse to report	**Language:** English, Other, Indian (includes Hindi and Thai Spanish, Russian)
Who may we thank for referring you to our office?	Phone ( )	
By signing below I hereby certify that the above information is true and correct to the best of my knowledge and belief. X_____	Date:	You will be required to provide a government issued photo ID at the time of service.

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Medical History

Date ____/____/____ Age _____

Patient's Name _____ Date of Birth____/____/____

Form completed by _____ Relation (if other than patient) _____

Sex: □ Male □ Female If female, are you pregnant? □ Yes □ No Number or children _____

***** What medical concern brings you in today?** _____
_____
_____

Current Medical History Are immunizations up to date? □ Yes □ No Are you a smoker? □ Yes □ No
Do you take calcium, multivitamins, antacid? □ Yes □ No
Do you drink alcohol? □ Yes □ No Last colonoscopy ___/___/___ Last Dexa Scan ___/___/___
Do you use recreational drugs? □ Yes □ No Last mammogram ___/___/___ Last pap smear ___/___/___

Current Medications

Medication	Dosage	How often do you take

Drug Allergies? □ Yes □ No Describe: _____

What is your pharmacy name & number? _____

Past Medical History Have you ever been hospitalized or had surgery? □ Yes □ No

If yes, please list reason or surgeries _____

Have you ever had a serious medical problem? □ Yes □ No
If yes, please list (e.g. high blood pressure, diabetes, high cholesterol etc…)
_____
_____

Family History Please list family medical history (e.g. cancer, heart disease, anemia, diabetes etc…)
_____
_____

Work History Occupation: _____ □ Retired □ Disabled □ Other _____

Are you: □ Single □ Married □ Partner □ Separated/Divorced □ Widowed

Physician Comments:
_____
_____
_____
_____ **REVIEWED BY** _____

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J.C. Healthcare & Associates reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice

2. Missed without calling to cancel (no call/no show)

Cancellation Fee: New Patient $25.00
Established Patient: $15.00

Patient / Parent or Guardian Signature:

_____ Date: _____

J.C. HEALTHCARE & Associates

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

J.C. HEALTHCARE & Associates

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PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice to Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this consent

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Patient Name (print): _____

This Acknowledgement was signed by: _____
Patient Signature

Relationship to Patient (if other than patient): _____

Date: _____/_____/_____

Witness Signature: _____
Practice Representative

Date: _____/_____/_____