forward
HEALTH SOLUTIONS, PLLC

FAX COVER SHEET

PLEASE FAX YOUR COMPLETED FORMS TO US ***2 BUSINESS DAYS PRIOR*** TO YOUR APPOINTMENT.

FAX TO FORWARD HEALTH SOLUTIONS AT: 601-450-2079

OF PAGES BEING FAXED (INCLUDING COVER SHEET) _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

DATE OF APPOINTMENT: _____

TIME OF APPOINTMENT: _____

APPOINTMENT WITH: _____

Dr. Boyd or Lynda Colbert

THANK YOU…WE LOOK FORWARD TO YOUR VISIT!

NEW PATIENT INFORMATION

PERSONAL INFORMATION				
Name (Last, First, Middle)		Nickname	Date of Birth	Age
Maiden Name	Sex: Female Male	Spouse/Parent/Guardian (If under age 18)		
Address				
City, State, Zip Code		Patient E-Mail		
Home Phone	Work Phone	Cell Phone		
EMERGENCY CONTACT				
Emergency Contact Person	Phone	Relationship		
EMPLOYMENT INFORMATION				
Employer		Occupation		
Business Address		City, State, Zip Code		
GENERAL INFORMATION				
How did you hear about our practice?		Who referred you to our practice?		

PAYMENT INFORMATION

Agreement to Pay: I understand and agree that I am responsible for payment of my account *at the time of service,* including my appointment and any services or supplements provided to me.

We accept cash, personal checks, VISA and MasterCard. Should your check be returned for non-sufficient funds, there will be a $25 charge and you will need to pay with a cashier's check. Patients are responsible for all costs associated with collections on their accounts.

I also agree that if I do not give a 24-hour notice of cancellation for my appointment or scheduled services, I will be charged for them.

Insurance Patients: We ***DO NOT*** accept any insurance. We would be happy to provide you with an itemized invoice and forms so you may submit them to your insurance company. Note: Not all insurance companies will reimburse you for our services.

Medicare Patients: ***We are an opt-out provider and you cannot bill Medicare*** for your visits or services.

Patient's Signature	Date

YOUR MEDICAL INFORMATION AND HISTORY

Name (Last, First, Middle)	Nickname	Date of Birth

Symptoms to be addressed:

Treatments to date:

Allergies/Reactions (Please list any drug, food or environmental allergies and your reactions)

Allergy	Reaction

List current medications and supplements

Medication/Supplement	Dose	Frequency	Duration

Social History

Marital Status Single ___ Married ___ Divorced ___ Widowed ___

Exercise Never ___ Seldom ___ Weekly ___ Daily ___

Type and duration of exercise: _____

Height _____ Weight _____

Habits

Tobacco Never smoked ___ Past tobacco use ___ Date quit _____
Current tobacco use ___ Cigarettes per day _____

Alcohol Non-drinker ___ Rarely ___ Social ___ Regular use ___

Caffeine ___ Freq ____ Other drugs _____

YOUR MEDICAL INFORMATION AND HISTORY

Name (Last, First, Middle)	Nickname	Date of Birth

Current Symptoms

Sleep	Digestion	Bowels
☐ Restful ☐ Restless ☐ Hard to get to sleep ☐ Wake up often ☐ Get up during the night ☐ Bad dreams ☐ Other _____	☐ Adequate ☐ Poor ☐ Acid reflux ☐ Burp often ☐ Bloating ☐ Burning/pain in stomach ☐ Flatulence	☐ 3X daily ☐ Once per day ☐ Skip days ☐ Amount ☐ Normal ☐ Too little ☐ Too large
Stress	**FEMALES**	**MALES**
☐ Rate your stress level on a scale of 1 to 10, 10 being the highest. _____ ☐ Main reason for your stress _____ _____ ☐ What are you doing to decrease your stress _____ _____	☐ Last period _____ ☐ Number of days periods last _____ ☐ Present contraceptive _____ ☐ Last pap smear _____ ☐ Abnormal pap smear _____ ☐ Do you have menopausal symptoms? _____ ☐ When did symptoms start? _____ ☐ Are you taking any hormones? _____ ☐ Date of last bone density? _____	☐ Date of last prostate exam ____ ☐ Date PSA checked _____ ☐ PSA #_____ ☐ Erectile dysfunction_____ ☐ Erections less strong____ ☐ Performance decreased ___

Family (Include age, health (good, fair, poor) or, if deceased (age at death and cause)	
Father	Spouse
Mother	
Siblings	Children

FAMILY HISTORY

Name (Last, First, Middle)	Nickname	Date of Birth

Have **you or any blood relative** (parent, grandparent, aunt, uncle, siblings, children) had the following? Check any that apply.

Medical Condition	**Self**	**Relationship**	**Medical Condition**	**Self**	**Relationship**
Acid reflux			Crohn's Disease		
Adrenal fatigue			Cushing's disease		
Allergies			Defibrillator/pacemaker		
Alzheimer's			Depression		
Anemia			Diabetes		
Angina			Drug/alcohol problem		
Anorexia Nervosa			Emphysema		
Aneurysm			Epilepsy		
Anxiety			Fibromyalgia		
Arthritis			Gall bladder stones		
Arthritis, Rheumatoid			Glaucoma		
Asthma			Glomerulonephritis		
Atrial fibrillation			Goiter		
Balloon or stent			Gout		
Bipolar Disorder			Heart attack		
Bleeding tendencies			Heart disease		
Blood clots			Hepatitis		
Blood disease			High blood pressure		
Bronchitis			High cholesterol		
Bulimia			High triglycerides		
Cancer, brain tumor			Hyperthyroidism		
Cancer, breast			Hypothyroidism		
Cancer, cervical			Inflammation of pancreas		
Cancer, colon			Irregular heartbeat		
Cancer, kidney			Irritable bowel		
Cancer, leukemia			Kidney disease		
Cancer, liver			Kidney stones		
Cancer, lung			Leukemia		
Cancer, lymphoma			Liver disease		
Cancer, melanoma			Meningitis		
Cancer, ovarian			Mental illness		
Cancer, prostate			Migraine headaches		
Cancer, skin			Mononucleosis		
Cancer, uterine			Multiple Sclerosis		
Cataracts			Neuropathy		
Chronic Fatigue Syndrome			Chronic renal failure		
Chronic lung disease			Colon polyp		
Congestive heart failure			Osteoarthritis		

FAMILY HISTORY - continued

Name (Last, First, Middle)	Nickname	Date of Birth

Have **you or any blood relative** (parent, grandparent, aunt, uncle, siblings, children) had the following? Check any that apply.

Medical Condition	**Self**	**Relationship**	**Medical Condition**	**Self**	**Relationship**
Osteoporosis			Rheumatic fever		
Parkinson's Disease			Schizophrenia		
Peptic ulcer disease			Seizure disorder		
Pernicious anemia			Seizures		
Pneumonia			Sleep apnea		
Polymyalgia Rheumatica			Stroke		
Psoriasis (skin disease)			Thyroid disease		
Psychological problems			Tuberculosis		
Urinary tract infections			Ulcerative colitis		
Obesity			Ulcers		
Obsessive-Compulsive			Urinary tract infections		

Past Surgical History – Which surgeries have you had?			
Surgery	**Date**	**Surgery**	**Date**
Adenoidectomy			
Appendectomy			
Bowel, gallbladder			
Cosmetic procedures			
Fracture or concussion			
Hemorrhoidectomy			
Hernia repair			
Hysterectomy			
Nose, ear, mastoid or sinus			
Stomach			
Tonsillectomy			
Vasectomy			
Other			

Menopause Rating Scale (MRS)

Name: _____Date of Birth_____

Today's Date: _____

Which of the following symptoms apply to you at this time? **Place one "X" for each symptom.**

	Does not Apply	Mild	Moderate	Severe	Extremely Severe
1. Hot flashes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Revised: 11-01-10

HIPAA NOTICE OF PRIVACY PRACTICE

FORWARD HEALTH SOLUTIONS, PLLC

General: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), set rules that regulate how a person's personal health information can be disclosed to others.

Protected Health Information: This includes oral or recorded information created or received by the healthcare provider, health plan, employers, or others concerning physical or mental health provisions or payment for healthcare.

How your medical information will be used and disclosed: We will use your protected health information as part of patient care. For example, your protected health information may be used by the healthcare professional treating you, by the business office processing your payment for services rendered, or by our staff reviewing the quality and appropriateness of the care received.

We may also use and/or disclose your medical information:

- when required to determine our compliance with relevant laws;
- for public health concerns, such as reportable infections, diseases and injuries.
- in the course of certain judicial or administrative proceedings;
- for law enforcement purposes and /or other specialized governmental functions;
- to a coroner, medical examiner, or funeral director.
- to prevent or lessen a *serious* threat to the health and safety of yourself and others;
- as authorized by laws related to Workers Compensation programs;
- to another provider to whom we refer you to for further care;
- to family members or any other person you specify here:
  _____ (please print) and initial _____

Your rights regarding your protected personally identifiable information include:

- the right to request restrictions on certain uses and disclosures;
- the right to receive communication from us in a confidential manner;
- the right to inspect and copy your medical information;
- the right to request an amendment to your medical information;
- the right to receive an accounting of the disclosures for up to six years prior to your request;
- the right to request a copy of this notice;
- the right to complain to Forward Health Solutions, PLLC and the U.S. Department of Health Human Services.

Disclaimer: Forward Health Solutions, PLLC strives to respect and maintain our patients' privacy. A new law with legal terms and unmanageable expectations will not suddenly make any healthcare facility perfect. We will continue to make every effort to provide the best quality healthcare to you and your family in a manner that protects your privacy. Further, we will never intentionally breach your confidence by disclosing **private** information without your consent. However, if you feel you have **serious** privacy issues or concerns, you may want to consider using another facility. It is impossible to soundproof our office or guarantee that someone will not overhear a conversation, see your name somewhere, or even meet you in our lobby.

Please speak with any staff member if you have any questions regarding this policy. If you feel your privacy rights have been violated, please contact our Privacy Officer: Rebecca Boyd, DO, Forward Health Solutions, PLLC, 140 Milbranch Road, Suite 1500, Hattiesburg, MS 39402, (601) 450-2077

_____	_____	_____
PATIENT'S SIGNATURE	DATE	WITNESS

FORWARD HEALTH SOLUTIONS, PLLC

OFFICE POLICY

Patient's Name: _____ DOB_____

Initial below:

___ **Primary Care and Emergencies**

- We do not assume treatment of chronic medical illnesses, general medical care (including pap smears, mammograms, and digital rectal exams).
- We do not prescribe refills of your routine medication prescribed by other physicians.

___ **Lab Work**

- We offer lab work at a significantly-reduced cost compared to many outside clinics. If you choose to have us do your lab work, payment is due at the time your blood is drawn.
- If you choose to obtain your lab work from an outside lab, you will be responsible for obtaining your lab results, ensuring they are complete, and bringing them with you to your appointment. If you have an appointment and we do not have all your labs, you will be charged for your scheduled appointment, and will need to schedule an appointment to review the labs we did not receive.

___ **Payment**

- **Agreement to Pay**: I understand and agree that I am responsible for payment of my account *at the time of service,* including my appointment and any services or supplements provided to me.
- We accept cash, personal checks, VISA and MasterCard. Should your check be returned for non-sufficient funds, there will be a $25 charge and you will need to pay with a cashier's check. Patients are responsible for all costs associated with collections on their accounts.
- I also agree that if I do not give a 24-hour notice of cancellation for my appointment or scheduled services, I will be charged for them.
- **Insurance Patients**: We ***DO NOT*** accept any insurance. We would be happy to provide you with an itemized invoice and forms so you may submit them to your insurance company. Note: Not all insurance companies will reimburse you for our services.
- **Medicare Patients:** ***We are an opt-out provider and you cannot bill Medicare*** for your visits or services provided by Forward Health Solutions.

___**Appointment No-Shows, Cancellation and Late Fees**

- We do not overbook patients to account for no-shows. If you cannot keep your appointment, please give us at least 24 hours notice. **If you cancel your appointment, for any reason, within 24 hours of your appointment, you will be charged for the missed appointment.**
- If you schedule an IV and do not call to cancel your session within 24 hours, you are responsible for the payment of the IV.
- If you will be unavoidably late for your appointment, please let us know. If you arrive more than 15 minutes late, you will be charged for the missed appointment. If time allows, we will see you for the balance of your appointment time.

___ **Medication Refills**

- Prescription refills should be requested at appointments, whenever possible.
- Many pharmacies do not routinely carry all prescription drugs; therefore, please request your refills within a few days of taking your last dose.

___ **Supplements**

- Supplements may not be returned. All supplement sales are final.

___ **Confidentiality**

- Your medical information is strictly confidential. We will not release it to anyone, including family members, without your written consent. However, if you wish, a family member may accompany you to your appointments without a written consent.
- If you want a copy of your records sent to another physician, we will require a written authorization from you.

___ **Employee Work Environment**

- Forward Health Solutions is committed to providing a work environment for our employees that is free of harassment of any nature, including sexual harassment or harassment based on such factors as race color, religion, national origin, age, sex, marital status, and disability. Any patient who harasses a staff member or any other patients will be dismissed as a patient.

By signing this form, I acknowledge that I have read and agree to abide by the above office policy. I also understand that if I abuse or do not follow these policies, I may be discharged from the clinic.

Patient's Name (Print): _____ Patient Signature _____ Date _____

Witness _____ Date _____

Revised January 20, 2011