Consent to Medical Treatment

PLEASE PRINT CLEARLY

In presenting for diagnosis and treatment, I _____, being over the age of eighteen (18) or an emancipated minor for:

❑ Myself or my (check one) ❑ Mother ❑ Father

(Enter Patient's Name) _____, for whom I am the legally authorized representative, hereby voluntarily consent to the rendering of such care encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering medical treatments by the medical staff and their assistants, including nurse practitioners, physicians' assistants, registered nurses, medical assistants, or their designees as is necessary in the medical staff's judgement.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition, or the condition of mother, father, or any person for whom I am executing this Consent to Medical Treatment.

I understand that by signing this Consent to Medical Treatment, I am consenting to the release of medical information to other physicians, institutions, or agencies accepting patient for medical or institutional care, and consent to the release of medical information to other entities for treatment, diagnostic procedures and give permission to release data (medical or personal) to such government agencies as required by the medical providers of Inova, Simplicity Health, and by laws, rules and regulations, and by contract.

I understand that this consent form will be valid and remain in effect as long as I continue to receive medical care at Simplicity Health.

This form has been explained to me and I fully understand this Consent to Medical Treatment and agree to its contents.

Signature of Patient: _____ Date: _____
(Required)

Signature of witness who explained then content of this "Consent to Medical Treatment" form:

Signature of Witness: _____ Date: _____
(Required)

Signature of Legally
Authorized Representative: _____ Date: _____
(If Required)
Relationship of Legally Authorized Representative to Patients:

(Check One Only)
❑ Parent ❑ Legal Guardian ❑ Power of Attorney ❑ Other Legally Authorized Representative

Registration Form

In order to serve you promptly, we need the following information. Fill out each item or put N/A (not applicable).

PLEASE PRINT CLEARLY

Are you a recipient of (please check one): ❑ Medicare ❑Medicaid

NOTE: Simplicity Health does not accept patients who are Medicare or Medicaid recipients.

➢ **Payment of $40 is required for each 4-weeks of access to the clinic's services**

Patient's Name: _____
LAST FIRST MI

Other Name (Example: Maiden name, etc) _____

Date of Birth: _____/_____/_____ Social Security #:_____-_____-_____

Primary Phone #: (_____) _____-_____ Secondary Phone # :(_____) _____-_____

Mailing Address: _____
Street Apt. # City State Zip Code

Sex: ❑Female ❑Male

Marital Status: ❑ Married ❑ Single ❑ Domestic Partner
❑ Divorced ❑ Separated ❑Other: _____

Primary Language: _____

Race: _____ ❑ Decline Race Ethnicity _____❑ Decline Ethnicity

Employment: ❑ Full-time ❑ Part-time ❑ Retired ❑ Disabled ❑ Homemaker

Emergency Contact: _____ Relationship to patient: _____

Emergency Contact Tel. # (_____) _____-_____ Cell # (_____) _____-_____

Guarantor's Name: _____ Relationship to Patient: _____

Guarantor's Mailing Address: _____
Street Apt. # City State Zip Code

Guarantor's Phone #: (_____) _____-_____

Please read carefully and sign.

X _____ _____
(Patient Signature) Date

PATIENT REPRESENTATIVE RELEASE AUTHORIZATION

By completing this form I authorize Simplicity Health to discuss/release my protected health information to one or more representatives identified. I may add or delete up to three individuals at any time by completing this authorization. By signing this form I give permission to Simplicity Health to discuss/release protected health information with the below named party(s).

1. Patient Information

Name: _____)_____

Date of Birth: ____ / ____ / _____ Telephone # (Home) _____ (Cell) _____

Street: _____

City: _____ State: _____ Zip: _____

2. Patient Representative(s):

Please identify up to two individuals to be your Patient Representative. Please ensure that the designated individual(s) below will need to provide the following information on you prior to Simplicity Health discussing/releasing personal health information on your behalf:

- ❑ Patient Name
- ❑ Patient Date of Birth
- ❑ Patient Address
- ❑ In addition they will also be asked to provide their name and date of birth for identification purposes only.

Please check one of the following boxes: ❑ Add ❑ Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released:

❑ All medical information ❑ Other (please be specific): _____

3. Authorization

I authorize Simplicity Health to discuss my medical care with the individual(s) identified above. I understand there is no expiration date, and I may add or delete up to three individuals at any time by completing a new authorization. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Simplicity Health. I understand the revocation will not apply to information that has already been provided in response to this release.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(NOT VALID UNLESS WITNESSED)

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information will be released by signing:

Patient Signature: _____ Date: _____

Medical History

Please fill out the following questions to the best of your ability. The more information you can give us before your appointment the more time we will have to discuss your concerns.

Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please check the appropriate column if you have ever been diagnosed with the following illnesses

YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Liver Problems
❑	❑	Diabetes	❑	❑	Anemia
❑	❑	High Cholesterol	❑	❑	Anxiety or Depression
❑	❑	Cancer	❑	❑	Gout
❑	❑	Thyroid Problems	❑	❑	Stroke
❑	❑	Heart Problems	❑	❑	Headaches
❑	❑	Stomach Problems (Heartburn, Ulcers)	❑	❑	Prostate Problems
❑	❑	Intestinal Problems (colitis, irritable bowels, chronic diarrhea or constipation, black/tarry stools)	❑	❑	Kidney Problems
			❑	❑	Skin Problems
			❑	❑	Arthritis/Osteoporosis
			❑	❑	Other Problems _____
❑	❑	Asthma/Lung Problems			

Have you ever been hospitalized? If so:

Reason?	When?	Type of Surgery or Medical Condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Please list ALL medications you are currently taking, including vitamins, herbs, supplements, and medication that you only need occasionally (Tylenol, allergy pills, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list any allergies you have AND the reaction that they cause (rash, breathing problems, nausea, etc.).

Medication		***Food Allergies***		***Environmental Allergies*** (pollen, grasses, dogs/cats, bee stings, etc.)	
Item	Reaction	Item	Reaction	Item	Reaction

SimplicityHEALTH

FAMILY MEDICAL HISTORY

Please list all your immediate blood relatives and indicate any medical problems they may have if you know this information

	Present Age	Medical Problem	Age at Death / Reason
Father			
Mother			
Brothers			
Sisters			
Children			

If you know your grandparents' medical history, please let us know (Specifically any heart disease, diabetes, cancer, etc.)

_____

_____

Yes	No		
❑	❑	Do you smoke? If yes, number of cigarettes per day? _____	How old were you when you started? _____
❑	❑	Do you drink Alcohol? If yes, how much do you drink each week? _____	
❑	❑	Do you exercise? If yes, what type of exercise? _____	How often? _____
❑	❑	Are you at risk for HIV?	
❑	❑	Do you wear seatbelts?	
❑	❑	Are you feeling threatened by anyone you know? If the answer is yes, would you like to discuss this? ❑ Yes ❑ No	

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle the number that applies for each statement)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
➢ Having little interest or pleasure in doing things	0	1	2	3
➢ Feeling down, depressed, or hopeless	0	1	2	3

REVIEWD BY: _____ DATE: _____