CREDO
FAMILY MEDICINE

Patient Intake Form

- Name: *First*:_____ *Middle*: _____ *Last*:_____

Date of Birth: _____/_____/_____ Gender: ____Male ____Female SSN:_____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____

Email Address: _____

Marital Status: ____ Single ____ Married ____ Divorced/Legally Separated ____ Widowed

- Guarantor: _____
- ***Emergency Contact:*** _____

Phone: (_____)_____ ***Relationship to Patient:*** _____

- Patient Employer: _____
- Preferred Pharmacy: _____ • *How did you hear about us*? _____

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1 **Primary Insurance**: _____

Policy Holder Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Gender: ___Male ___ Female

Address: _____

If employer provides insurance, list employer here:_____

Phone No.: (_____)_____

2 **Secondary Insurance**: _____

Policy Holder Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Gender: ___Male ___ Female

Address: _____

If employer provides insurance, list employer here:_____

Phone No.: (_____)_____

3 **Tertiary Insurance:** _____

If the policy holder information is the same as listed above, please indicate which information applies: **1** ___ **2** ___

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Consent and Financial Policy

Treatment

- I hereby consent for Credo Family Medicine to administer health care in all forms, including but not limited to: medical care, wellness and/or preventative care, diagnostic care, other care, treatment, services, examinations, tests, consultations, procedures, and/or evaluations, including in-person, virtual, or telephonic care to evaluate and treat me and my medical conditions or the minor/child _____ in my legal care as Parent/Legal Guardian. I agree that I have the legal authority to act on behalf of said minor and that said minor legally cannot sign for himself/herself.
- I hereby acknowledge that I am aware of the Mission, Values, and Ethics Statements of Credo Family Medicine (as found on their website www.credofamilymedicine.com), and I consent to receiving health care from Credo Family Medicine within the stated parameters of these statements.
- I agree to treat all staff, agents, other patients, and visitors that I may encounter with respect and charity and understand that if I behave in a threatening, rude, or disruptive manner that I will be subject to dismissal from the practice.

Financial Responsibility

- I hereby acknowledge that I am financially responsible for all services and health care administered to me from Credo Family Medicine, both in person and by any form of telehealth, virtual, or telephonic care. I agree that I am responsible and will pay all applicable balances on my account, including co-pays, deductibles, and co-insurance amounts when applicable. I also agree that I am financially responsible for any services not covered by my insurance or for which my benefits have been exhausted, any out-of-network benefits, and for any services for which coverage is denied. I agree that I will pay my balances with Credo Family Medicine by the dates specified on my account. I acknowledge that if I fail to pay said balances, I may be sent to collections and will be responsible for all processing fees and collection costs including applicable attorney fees and court costs. I understand that if I do not submit my insurance information to Credo Family Medicine within 30 days of service, the insurance will not be applied to that service due to timely filing rules of the insurance company.
- I understand that Credo Family Medicine does not participate in or accept Medicaid insurance plans
- I hereby assign Credo Family Medicine with the ability to access my rights to be reimbursed by my insurance company or other third-party benefits contract. I hereby request that all payments for my health care be made from my insurance company to Credo Family Medicine on my behalf. In the event such payments are not made to Credo Family Medicine from the insurance company, I agree to forward such payments to Credo Family Medicine. I hereby grant permission for Credo Family Medicine to transfer/transmit/receive information regarding my applicable benefits and coverage with my insurance company or third-party benefits contract.
- I acknowledge that Credo Family Medicine is not financially responsible for any costs that I may incur related to their recommendations, orders, or directives for care including but not limited to: lab, imaging, hospital, referral, out of network care, and any other costs. If I elect to receive out of network care, I am solely responsible for this decision and recognize that this will likely increase the cost of care and that it may not be covered by my insurance. I hold Credo Family Medicine harmless for any costs associated with care received here or elsewhere that is not covered by my insurance. I agree that it is my responsibility to know and understand the benefits and limitations of my health insurance policy before receiving care, here or elsewhere, and not the responsibility of Credo Family Medicine.
- If I miss a scheduled appointment without formally cancelling greater than 24 hours in advance of the appointment time, I will be subject to a $60 fee. This will be billed directly to me and not covered by insurance.
- If I am more than 10 minutes late to my appointment, out of respect for the other patients following my appointment, Credo reserves the right to reschedule my appointment to a later time and the $60 fee will apply.
- I will be charged a $50.00 service fee for the completion of paperwork such as for FMLA, Disability, and the like.
- If payment is received via check and my payment is denied for insufficient funds, a $25.00 fee will be applied.
- The fees listed above are not covered by insurance and subject to change at any time.

Privacy Acknowledgement

- I hereby consent for the providers and those involved in my medical care of Credo Family Medicine to transfer/transmit/receive my health information as may be required to any person, corporation, or agency who Credo Family Medicine has reason to believe is legally responsible for processing the payment of received health services on my behalf. I further consent that Credo Family Medicine and all providers and those persons involved in my medical care may transfer/transmit/receive my health information to such affiliated health professionals as deemed necessary by Credo Family Medicine for the purposes of fulfilling the administration of my medical care.
- _____ I acknowledge that I have been offered the opportunity to review the Notice of Privacy Practices which are also available on our website

Patient Name: _____

Patient/Parent/ Legal Guardian Signature: _____

Guardian's Relationship to Patient: _____ Date: _____/_____/_____

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Patient History Form

Patient Name: _____ **Maiden Name:** _____

Date of Birth: _____/_____/_____ **Age**: _____ **Sex**: ___M ___F **Birthplace**:_____

Previous Primary Physician: _____ **Last Visit**: _____

Social History

1. Marital Status:	Single: _____ Married: _____ Divorced/Separated: _____ Widowed: _____ *Spouse Name:*_____ *or* *Partner Name:*_____
2. Race/Ethnicity:	
3. Primary Language:	
4. Who lives in the home?	
5. Pets in the home?	
6. Occupation:	
7. Religious Preference:	
8. Alcohol Use:	Never: ____ Current: ____ Former: ____ *Amount per week:* _____ *If Former, how long ago was last use?* _____
10. Tobacco Use:	Never: ____ Current: ____ Former: ____ Secondhand:____ *Amt per day:* _____ *Total years:* _____ *If Former, how long ago was last use?:* _____
10. Drug Use:	Never: ____ Current: ____ Former: ____ *Type Used:* _____ *If Former, how long ago was last use?* _____
11. Living will/POA?	POA: _____ Code Status: (DNR/FULL) _____ Declines: _____

Medical History

Preventative Care			
When was your last?	Date	Where	Results
Colonoscopy			
PAP Smear			
Mammogram			
Bone Density Scan			

Medical Diagnosis/Problems – *Please indicate medical diagnosis and date of diagnosis*					
Diagnosis	**Yes, Type?**	**Date**	**Diagnosis**	**Yes, Type**	**Date**
Alcoholism			High Cholesterol		
Anemia			HIV/AIDS		
Aneurysm			Infertility		
Anxiety/Depression			Kidney Disease/Stones		
Arrhythmia			Liver Disease/Hepatitis		
Arthritis			Migraines/Headaches		
Asthma			Osteoporosis		
Bleeding/Clotting Problems			Pacemaker		
Cancer			Prostate Enlargement		
Colon Problem/Polyps			Psychiatric Illness		
Diabetes; Type 1 or 2			Pulmonary Embolism		
Dialysis			Skin Problem		
Emphysema/COPD			Sickle Cell Anemia		
Epilepsy/Convulsions			Sexually Transmitted Disease		
Eye Problems			Stroke		
Gall Bladder Disease			Suicide Attempts		
Gout			Thyroid Problems		
Heart Disease			Ulcers		
Heartburn/Reflux			Urination Problems		
Other, please specify:					

Drug Allergies	Date	Reaction
1)		
2)		
3)		

Surgeries/Hospitalizations	Date	Reason
1)		
2)		
3)		

PEDIATRIC PATIENTS ONLY – BIRTH HISTORY					
___*Vaginal*	___ *C-section*	___*Preterm*	___ *Full Term*	___*Shoulder Dystocia*	___*NICU Admit*
Pregnancy Complications (i.e. diabetes, hypertension)?					

FEMALE PATIENTS ONLY – OBGYN HISTORY							
Age of First Menses:		Duration of bleeding:		Cycle Length in Days:			
Menopause Status:	___ Pre ___ Peri ___ Post			Age of Menopause:			
Natural family planning or birth control? What kind?							
Total Pregnancies	Number of Full Term	Number of Preterm	Number of Miscarriages	Number of Abortions	Ectopic Pregnancies	Multiple Births	Number Living
Comments or complications?							

Vaccination History

Are you to date with vaccinations?	Yes: _____ No:_____ Unsure: _____ Refused: _____
Where have you received vaccines?	

Medication List

Medication	Dosage/Frequency	Diagnosis
1)		
2)		
3)		
4)		
5)		
6)		

Family History

Family Health Status					
	Alive	**Health Status/Medical Diagnosis**	**Deceased**	**Cause of Death**	**Age Died**
Father					
Mother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

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Vaccination Schedule Form

PEDIATRIC PATIENTS ONLY

I, _____, the parent/legal guardian of

_____

born on _____ _____ of _____ choose to have the following vaccination schedule for my child. Credo Family Medicine has informed me that the standard of care is the CDC recommended vaccination schedule, which they recommend. I understand the benefits of vaccinating and the potential consequences of not vaccinating my child using the recommended schedule and am aware that the benefits of vaccination and the potential consequences of not vaccinating are also available at www.cdc.gov/vaccines/pubs/vis/default.htm. As the parent/legal guardian, I want my child to receive:

☐ CDC Schedule (Recommended)

☐ Other (please specify) _____

In the event I choose a vaccination schedule outside the recommended CDC vaccination schedule listed above, I have been informed, and I understand that I may be putting my child or others at risk of serious illness if such diseases are contracted by my child that otherwise could have been prevented through vaccination on a regular schedule.

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____/_____/_____

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Medical Records Request Form

Patient Full Name: _____

Address: _____

Phone Number: (_____)_____ Date of Birth: _____/_____/_____

I, _____, (Patient/Guardian) hereby grant permission for:

Clinic Name/Physician to Be Requested: _____

Address: _____

Fax Number: (_____)_____ to release my health information to:

Credo Family Medicine
10050 Auburn Park Dr.
Fort Wayne, IN 46825
Phone: (260) 432-6459 / Fax: (260) 240-5284

FOR OFFICE USE ONLY

The health information to be released shall include the following:

- ☐ Entire Record, including all categories below _____
- ☐ Hospital Notes _____
- ☐ Emergency Reports _____
- ☐ Office Notes _____
- ☐ Lab Results _____
- ☐ Imaging and Other Test Results _____
- ☐ Nursing Home/Home Health/Hospice/Other Physician Records _____
- ☐ Financial History Report _____
- ☐ Other: _____

Purpose of release of information: _____

I understand that I may revoke this authorization by writing to the contact for Credo Family Medicine at any time, except to the extent that this authorization has already been exercised. I hereby hold harmless and receiving party from any legal liability that arises from the release of my health information.

I hereby grant permission for Credo Family Medicine to keep a copy of my medical records for their own records.

Patient/Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____/_____/_____

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Medical Records Release Form

Patient Name: _____

Date of Birth: ____/_____/_____

I, _____, hereby grant permission for Credo Family Medicine to disclose, in complete or partial form, medical records to the parties listed below. By signing this authorization, I understand that this release may include any and all protected health information including any information pertaining to: substance abuse, sexually transmitted diseases, HIV/AIDS, treatment for psychiatric disorders, demographics, insurance, and billing information.

- I am aware there is no requirement to sign this authorization form to receive treatment from Credo Family Medicine
- If this authorization is exercise, I am aware that any protected heath information disclosed to the authorized parties listed below will no longer be protected under the privacy obligations of Credo Family Medicine as the actions of these parties are beyond our control
- I am aware that I may revoke this authorization at any time by providing a signed written request to Credo Family Medicine

Relative/Representative: _____

Relationship/Role: _____ Phone Number: (____)_____

Relative/Representative: _____

Relationship/Role: _____ Phone Number: (____)_____

Relative/Representative: _____

Relationship/Role: _____ Phone Number: (____)_____

_____

Date: _____/_____/_____

Patient/Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____