Snow Family Medicine, LLC

Dear new patients,

Welcome! We are happy to be your new primary care practice. Before we see you for your first appointment, we will need to know a little bit more about you. Please complete this packet and bring it in on the day of your New Patient visit.

Our Practice Mission Statement:

At Snow Family Medicine, we believe that the mind, body and soul of the individual should be the focus of all patient-provider relationships. As healthcare professionals, we strive to provide patient-centered, quality care, in a convenient, and calming environment, while maintaining the privacy, respect, and collaborative rapport with patients and families.

We treat patients of any age, ranging from newborn to elderly. We want families to have the convenience of having one primary care provider from childhood to adulthood.

We believe that mental health is as important as physical health. We have a team of behavioral health counselors connected with our office so that we can better treat our patients mind and body.

We understand that healthcare system costs are constantly evolving. Our staff is committed to provide a professional and pleasant experience for our patients during these changes, while striving to keep a cost-efficient approach

Feel free to make note of any questions that you may have for us!

_____

_____

_____

_____

Patient Registration:

First name: _____ Last name: _____ MI:____

DOB: _____ Gender: M / F Gender Identity: _____ SSN: _____

Cell: _____ Home: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Info:

(If child does not live with <u>both</u> biological parents, list who has legal custody of the child.)

Name: _____ Name: _____

DOB: _____ DOB: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Child's Current Living Situation

With whom does the child currently reside?

- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-mother
- ☐ Step-father
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Foster Mother
- ☐ Foster Father
- ☐ Other: _____

Sibling's Name	Age	Sex	Full/Step

Current Concerns about your child:

- ☐ Aggression
- ☐ Biting
- ☐ Hitting
- ☐ Overactivity
- ☐ Self-injury
- ☐ Temper tantrums
- ☐ Anxious
- ☐ Depressed
- ☐ Inattentive
- ☐ Language abilities
- ☐ Muscle tone
- ☐ Peer relationships
- ☐ School environment
- ☐ Sleep problems
- ☐ Medication
- ☐ Appetite/Food concerns
- ☐ Preoccupations
- ☐ Self-help skills
- ☐ Toilet training
- ☐ Motor skills
- ☐ Other: _____ _____
- ☐ Self-stimulatory behaviors: rocking, spinning, flapping hands

Medical History

Has your child ever experienced any of the following? *(If yes, please provide a brief explanation.)*

- ☐ Head injury
  _____
- ☐ Loss of consciousness
  _____
- ☐ Allergies to food or medication
  _____
- ☐ Surgery
  _____
- ☐ Ear infections
  _____
- ☐ Hospitalization
  _____

School History

Current School: _____ Grade Level: _____

Has your child had special education testing in school? *(Please include if you've had it done privately also.)*

- ☐ Psychological/Cognitive_____
- ☐ Psycho-Educational Evaluation_____
- ☐ Speech/Language _____
- ☐ Other _____

Is your child receiving any special education services at school? __Yes __No

Does your child have an Individualized Learning Plan/IEP? __Yes __No

Does your child currently see any specialists? *(dermatology, cardiology, podiatry, etc.)*

Specialty	Seen for	Date

Allergies *(to foods or medications)*

Allergen/Agent	Reaction

Medication History

Medication	Strength	Directions	Dates

Surgical Procedures and Hospitalizations

Surgical Procedure/Hospitalization	Facility	Date(s)

Personal Medical history

If you have experienced any of these medical conditions in your personal medical history, please check the corresponding box.

	ADD		Lung cancer
	ADHD		Lymphoma
	Alcoholism		Migraines
	Alzheimer's		Multiple sclerosis
	Asthma		Muscular dystrophy
	Autism		OCD
	Bipolar disorder		Other:
	Birth defects		Ovarian cancer
	Blood clots		Parkinson's disease
	Breast cancer		Physical abuse
	Celiac disease		Prostate cancer
	Cerebral palsy		Schizophrenia
	Childhood trauma		Sexual abuse
	Colon cancer		Sickle cell anemia
	Depression		Speech/language delay
	Eating disorder		Stroke
	Epilepsy/Seizures		Substance abuse
	Food allergies		Tics/Tourette's
	Glaucoma		Verbal abuse
	Hearing loss		Vision loss
	Heart attack		
	Heart disease		
	High blood pressure		
	High cholesterol		
	Huntington's chorea		
	Immune disorder		
	Infertility		
	Kidney disease		
	Leukemia		

Additional Notes:

Family Medical History

If any of your biological family members have been diagnosed with, or experienced any of the health conditions listed below, please us the maternal and paternal columns to specify the affected family member.

Maternal	Paternal	Condition
		ADD
		ADHD
		Alcoholism
		Alzheimer's
		Asthma
		Autism
		Bipolar disorder
		Birth defects
		Blood clots
		Breast cancer
		Celiac disease
		Cerebral palsy
		Childhood trauma
		Colon cancer
		Depression
		Eating disorder
		Epilepsy/Seizures
		Food allergies
		Glaucoma
		Hearing loss
		Heart attack
		Heart disease
		High blood pressure
		High cholesterol
		Huntington's chorea
		Immune disorder
		Infertility
		Kidney disease
		Leukemia

Maternal	Paternal	Condition
		Lung cancer
		Lymphoma
		Migraines
		Multiple sclerosis
		Muscular dystrophy
		OCD
		Other:
		Ovarian cancer
		Parkinson's disease
		Physical abuse
		Prostate cancer
		Schizophrenia
		Sexual abuse
		Sickle cell anemia
		Speech/language delay
		Stroke
		Substance abuse
		Tics/Tourette's
		Verbal abuse
		Vision loss

Additional Notes:

Immunization Policy

At Snow Family Medicine, the long-term health and wellbeing of our patients is very important to us. One way that we can provide care for our pediatric patients is by requiring that all patients/parents must comply with the recommended CDC guidelines for vaccines. The only exception to this policy will be in the case of TRUE medical contraindication or allergy. Religious exemptions are not permitted in this office.

Should patients/parents further decline these immunizations, we will provide care for the infant/child for 30 days from the date of this signed acknowledgement, after which time the patient will no longer be considered a patient under our care. The office will be happy to transfer medical records free of charge, directly to the office of the new pediatrician/primary care provider. Parents requesting copies of medical records may be required to pay a $25.00 medical records fee.

I hereby attest that I have read and acknowledge this information.

Printed Name: _____ Date: _____

Signature: _____

Controlled Substances Agreement

Controlled substance abuse has been and continues to be a major problem in healthcare. Due to this, Snow Family Medicine, LLC will not continue prescriptions of any controlled substances/opioids/narcotics previously prescribed to you by another provider. This policy is to protect you as the patient as well as the practice. If you are injured or are diagnosed with a condition that indicates the use of these medications, the provider may elect to do so. In case of this situation, we require a signed controlled substances agreement from the patient or guardian to keep in the patient's record.

Controlled medications are potentially dangerous. – Side effects and dangers include constipation, fatigue, drowsiness, mood changes, nausea, vomiting and anxiety. There is a risk of addiction, respiratory depression, and death. You understand that you cannot mix narcotics, benzodiazepines & stimulants with alcohol, and should use extreme caution when operating a motor vehicle.

You must take your medication exactly as prescribed. – You cannot increase medication without permission from me. All adjustments must be authorized and documented by the provider. If you increase your medication without approval, you will run out early and I can not prescribe additional medication.

This practice is the only office who can prescribe controlled medication to you. – You cannot obtain controlled medication from anyone else. If two different doctors are prescribing, the combination of these medications may cause death. This includes any other specialist, and/or emergency rooms or walk-in clinics. It is strongly recommended that you only use one pharmacy – We may require a printout from your pharmacy to confirm you are taking your medication as prescribed.

You are responsible for keeping your appointments for renewing your medication. – Controlled medications can only be prescribed monthly, in a 30 day supply or less. I cannot and will not renew controlled medication early, or if you missed your last controlled medication check appointment. These appointments will be required every 90 days in order to continue the prescription.

If you call the office repeatedly regarding your refill or a medication check - you will be in violation of this agreement. You may not ask a covering provider for a refill of this prescription.

You must have a urine toxicology screen at least once a year to confirm that you are using your medication properly. We are able to screen you at any time. You agree to take this medication only for the indicated condition, and not for any other purpose.

Do not throw out medications. If you need to change medications, you will be required to return the unused medication before I can provide you with a different medication.

Lost / Stolen medication. – You will be required to fill out a police report if you suspect someone has stolen your med. If you lose your med, or believe it to be stolen twice, we are unable to treat you with controlled medications.

The abuse and diversion of controlled substances is a criminal offense. - If criminal activity is suspected, I am obligated to report you to the authorities. I reserve the right to discontinue your controlled medications and/or discharge you from my practice for any violation of this agreement.

Printed Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

Notice of Primary Care Provider Selection

If your insurance plan requires a Primary Care Provider to be listed, please make sure you have Kristen Snow, FNP-BC listed on your card. If Kristen Snow is not listed as your PCP, your claim may be denied, and you will be responsible for the full amount of the visit

If you need to re-schedule your appointment to avoid receiving a bill, we will be happy to do so for you.

Patient name: _____ Date: _____

Signature: _____

Relationship to patient: _____

Optional: How did you hear about us? _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:
a basis for planning my care and treatment;
a means of communication among the health professionals who may contribute to my health care;

a source of information for applying my diagnosis and surgical information to my bill;

a means by which a third-party payer can verify that services billed were provided;

a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:
I have the right to review this Practice's Notice of Information practices prior to signing this consent;
that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;

I have the right to object to the use of my health information for directory purposes;

I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested; I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature: Date: Relationship to Patient:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Snow Family Medicine, LLC (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment, and health care operations (TPO).

With this consent, the Practice may call, email, and/or mail to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may collect and share with my pharmacy and health insurer information about my prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

With this consent, I agree to participate in telemedicine consults, if requested, with the understanding that all existing laws regarding my access to medical information and copies of my medical records apply to the telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers and other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Printed Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

IMPORTANT

No-Shows, Missed Appointments and Late Check-in Office Policy

- Please be advised that patients arriving **15** minutes late for their appointment will be considered a no-show and will need to be rescheduled.
- After **2** no-show occurrences, the practice may elect to discontinue your care with our providers, and you will need to seek care elsewhere.
- **NOTE:** You may receive a bill for visits that you do not arrive to and do not call ahead of time to cancel.

We are very understanding of life's unpredictability and will try to work with and accommodate you in the best way possible when rescheduling. We ask that you please be courteous of those who may need a visit with us urgently.

FOLLOW-UPS, SICK VISITS, SAME DAY APPOINTMENTS	$30.00
PHYSICAL EXAMINATIONS AND WELL-CHILD VISITS	$50.00

By signing this document, you accept the financial policies of Snow Family Medicine, LLC, as well as the understanding that you are financially responsible for all charges that may result from no-show occurrences.

Print name: _____

Signature: _____ Date: _____

Authorization for Release of Medical Record Information

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: ____ Zip code: _____

Records Requested From:	**Requested to be sent to:**
Facility Name: _____	*Snow Family Medicine, LLC*
Address: _____	2220 Plainfield Pike, Cranston, RI, 02921
City/State/Zip: _____	P: 401-585-8500
P: _____ F: _____	F: 401-942-2200

Please Review the following information (Check Only One)

- ☐ All records, including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.
- ☐ All records, not including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.
- ☐ Immunization records only

Note: If the patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party must provide legal documentation providing authority to do so.

This information will not be given, sold, transferred, or relayed to any other person not specified in this authorization without first obtaining my written consent which states the need for the proposed new use of this information, or the need for its being transferred to another person.

Understand that you, the patient will be liable for the reasonable transfer cost of $15.00 per patient if requesting your own private copy of your medical records.

Reason for Transfer: (Circle One)

Relocation Change of Provider Continuity of Care Change of Insurance Legal/Other

Printed Name: _____ Date: _____

Signature: _____ Relation to Patient: _____