James E. Lynch, MD, Heather Headrick APRN-cNP, Sherry Mitchell APRN, cNP

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Patient Information

Name: _____ Sex: _____ DOB: _____

SS#: _____ Email Address: _____

Cell Phone: _____ House Phone: _____

Preferred form of contact? ■ Cell Phone ■ Home Phone ■ Email ■ Not Specified

May we text you? ■ Yes ■ No May we leave a voice mail? ■ Yes ■ No

Address: _____ Apt: _____

City, State, Zip: _____

Ethnicity: ■ Hispanic/Latino ■ Not Hispanic/Latino ■ Decline to Specify

Preferred Language: _____ Race: _____

Emergency Contact: _____ Relationship to patient: _____

Phone Number: _____ ■ Cell Phone ■ Home Phone ■ Work Phone

Marital Status: ■ Single ■ Married ■ Divorced ■ Widowed Children: ■ Yes ■ No How many? _____

Occupation: _____ Work Phone: _____

Health Insurance

■ Private health insurance ■ Medicaid ■ Medicare ■ I am Self Pay

Past Medical History

Please list any Major Events/ Hospitalizations/ Surgeries: _____
_____
_____

Please list any other health conditions you presently suffer from: _____
_____
_____

Family History:

Food Allergies: ☐ Yes ☐ No If yes, who: _____
Heart Attack: ☐ Yes ☐ No If yes, who: _____
Diabetes: ☐ Yes ☐ No If yes, who: _____
Cancer: ☐ Yes ☐ No If yes, who: _____
Stroke: ☐ Yes ☐ No If yes, who: _____
Migraines: ☐ Yes ☐ No If yes, who: _____
Seizures: ☐ Yes ☐ No If yes, who: _____
Bleeding Problems: ☐ Yes ☐ No If yes, who: ____

Have you had any recent preventative care? ☐ Yes ☐ No If yes, please list: _____
_____
_____

Are you or could you be pregnant? ☐ Yes ☐ No LMP: _____

Do you have any dietary issues? ☐ Yes ☐ No If yes, explain: _____

Do you have any developmental issues? ☐ Yes ☐ No If yes, explain: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day: _____ How many years: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what kind: _____

Do you have any advanced directives? ☐ Yes ☐ No If yes, explain: _____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list the **NAME / DOSAGE / FREQUENCY** on the lines below:
_____
_____
_____
_____
_____
_____

Allergies:
Drug Allergies ☐ Yes ☐ No If yes, please list: _____
Food Allergies: ☐ Yes ☐ No If yes, please list: _____
Environmental Allergies: ☐ Yes ☐ No If yes, please list: _____

MINOR AUTHORIZATION (Only for patients 17 years old and younger)

Minor's Name: _____ Minor's DOB: _____

I, _____, attest that I am the custodial parent or legal guardian of the above- referenced minor and hereby authorize The Charter Clinic to administer treatment as it so deems necessary to the minor.

Name of Custodial Parent/Legal Guardian (please print): _____

Signature of Parent/Guardian: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS OR OTHERS

I authorize The Charter Clinic to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (The Charter Clinic may not release information or records to individuals/entities unless you identify them here):

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

The Charter Clinic will use my home phone and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

Patient Signature: _____ Date: _____

Other uses and disclosures:
We are permitted and/ or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigation;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- Court of administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

- **Access to Your Personal Health Information:** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You are entitled to one free copy of your personal health information. If you request additional copies you may be charged a nominal fee for copying and postage.
- **Amendments to Your Personal Health Information:** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reason for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.
- **Accounting for Disclosures of Your Personal Health Information:** You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.
- **Restrictions on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agree-to restriction if we believe the termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violates, you can file a complaint in writing with the Clinic Director/Privacy Officer at The Charter Clinic at 9402 N. May Avenue, Oklahoma City, OK 73120. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

AUTHORIZATIONS:

1. **Authorization to release medical information**
   I hereby authorize the release of medical and medication information pertinent to my care to the Doctors, Nurse Practitioners, Physician Associates, Medical Assistants, and Office Staff at The Charter Clinic.
2. **Privacy notice Acknowledgment**
   With my signature below, I acknowledge that I have read and received a copy of The Charter Clinic Notice of Privacy Practices.
3. **Informed Consent**
   I have been informed that I have the right to refuse any form of treatment. I understand the nature of treatment, and have been informed of the risks and possible consequences involved with this treatment.
4. **Financial Responsibility**
   I understand that I am fully responsible to The Charter Clinic for all charges I incur in this office, including deductible, co-pays, co-insurance, and all charges not covered by insurance, as detailed in The Charter Clinic's Financial Policy, available upon request.
5. **Consent to Treat**
   I understand that by signing the authorization below I am allowing for the Doctors, Nurse Practitioners, Physician Associates, Medical Assistants, and Office Staff to treat me and discuss the details of my treatment with me as well as with each other. I also understand that the staff of The Charter Clinic may utilize the Prescription Monitoring Program service to help decide the best steps of care for me.

I agree to the authorizations listed above and I certify that all the information contained in this booklet is complete and true to the best of my knowledge.

Signature of Patient: _____ Date: _____