Family Care Associates of Effingham

P.O. Box 665
Effingham, IL 62401

Date of Application:_____

Which physician are you applying for? ☐ Dr. Bierman ☐ Dr. Brummer ☐ Dr. Crowell ☐ Dr. Heischmidt

Who is applying? (Check all that apply) ☐ Self (Guarantor) ☐ Spouse/Partner ☐ Children

Guarantor's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle

Previous/Maiden Name:_____ ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

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

Home Ph:_____ Cell Ph:_____ Email:_____

Race: ◯ White ◯ Asian ◯ Native Hawaiian ◯ African American ◯ Hispanic ◯ Other Pacific Islander ◯ Other Race ◯ American Indian or Alaskan Native

Ethnicity: ◯ Hispanic ◯ Non-Hispanic Translator Needed: ☐ Yes ☐ No

Sexual Orientation: ◯ Straight ◯ Lesbian, gay or homosexual ◯ Bisexual ◯ Do not know ◯ Choose not to disclose

SSN:_____ Driver's License No.:_____ Occupation:_____

Employer: _____ Phone No.: _____ Ext.: _____

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

Spouse/Partner's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle

Previous/Maiden Name:_____ ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

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

Home Ph:_____ Cell Ph:_____ Email:_____

Race: ◯ White ◯ Asian ◯ Native Hawaiian ◯ African American ◯ Hispanic ◯ Other Pacific Islander ◯ Other Race ◯ American Indian or Alaskan Native

Ethnicity: ◯ Hispanic ◯ Non-Hispanic Translator Needed: ☐ Yes ☐ No

Sexual Orientation: ◯ Straight ◯ Lesbian, gay or homosexual ◯ Bisexual ◯ Do not know ◯ Choose not to disclose

SSN:_____ Driver's License No.:_____ Occupation:_____

Employer: _____ Phone No.: _____ Ext.: _____

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

Child's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle or expected due date

Child's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle

Child's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle

Child's Full Name:_____ DOB:_____ Gender:_____ Transgender ☐
Last First Middle

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In case of emergency, contact (Other than spouse):_____

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

Relationship:_____ Phone No:_____ Ext:_____

Current Physician: _____

Family History:	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children
No Known History	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐

A front and back copy of all insurance cards, including Medicare and/or Medicaid, as well as a copy of your current driver's license or photo ID must be included with the application.

We ask all patients to show their insurance membership card so that we may copy them. Medicaid cards must be presented at each visit or payment is due the day of service. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit such collection to the patient's account.

I give my consent to Family Care Associates of Effingham, S.C. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of my family members. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 90 days, I will be responsible for all fees incurred for collection and/or attorney fees.

Initials:_____ Date:_____

Family Care Associates is a medical home dedicated to the comprehensive healthcare of the patients we serve. We are not a walk-in clinic. When you complete your application, you agree to the medical care, fully managed by your new physician at Family Care Associates. Upon acceptance, previous medical records may be transferred to Family Care Associates. Complete our "Authorization for Release of Confidential Health Information" form directing records to Family Care Associates or contact your former physician's office and request your records be transferred. Thank you!

How did you hear about us? ◯ Radio ◯ Newspaper ◯ Friend ◯ Health Fair ◯ Website ◯ Other

Referred by:_____

Family Care Associates

Application for Medical Care

Please bring all of your current medications (in their BOTTLES) with you to your first appointment. If you are unsure of your medical history, please contact your previous physician and request a records transfer to Family Care Associates. If you need additional space, please use the back of this sheet. Thank you!

Name of Applicant _____

Date of your last **Mammogram**? _____

Date of your last **Colorectal Screening**? _____
(Includes Hemoccult, Colonoscopy, Flex Sigmoidoscopy)

Please list your **current medications** (including over-the-counter):

_____
_____
_____
_____
_____
_____

Please list any additional medications you have taken in the last **12 months** (including over-the-counter):

_____
_____
_____
_____
_____
_____

Medication Allergies:

_____
_____
_____

Side Effect/Reaction:

_____
_____
_____

Pharmacy Name and Phone (so that we may call with questions) _____

Please list your past and current **health problems**:

Current:

_____
_____
_____
_____
_____
_____

Past:

_____
_____
_____
_____
_____
_____

Please list any **hospitalizations, operations, or injuries** (please ***include dates***):

Condition(s): **Date:** **Does this require ongoing medical treatment? If so, what? When was your last treatment?:**

_____
_____
_____
_____
_____

_____
_____
_____
_____
_____

Which **doctors** have treated you in the past:

1. _____
2. _____
3. _____
4. _____

I hereby state all information given on this application/healthcare questionnaire to be true and correct. Once accepted as a patient, any information found to be untrue or incorrect could result in the dismissal of all individuals listed on this application.

_____ **Applicant Initals**

_____ **Date**

Thank you for choosing Family Care Associates!

Family Care Associates of Effingham, S.C.
1106 North Merchant, P.O. Box 665 Effingham, IL 62401
Phone 217-342-7000 Fax 217-342-7002

Authorization for Release of Confidential Health Information

Patient name:_____ Telephone:_____
Address:_____
City/State/Zip:_____ Date of birth:_____

I hereby authorize: Person/Institution/Other:_____
Address:_____
City/State/Zip:_____
Phone number:_____

To release protected health information regarding the above-named person to be exchanged

TO: Family Care Associates of Effingham, S.C.

I authorize the release of information pertaining to the following time periods:
From date(s):_____ To date(s):_____

The following types of information to be disclosed are as follows:

- □ History and physical examination
- □ Consultation reports
- □ Progress notes
- □ Operative reports
- □ Diagnostic reports (labs, x-rays, etc.)
- □ Physician discharge
- □ Emergency department record
- □ Social history
- □ Pathology reports
- □ Developmental disability records
- □ Alcohol/substance abuse
- □ HIV/AIDS
- □ Rehab Records
- □ Psychiatric outpatient notes (pre/post hospitalization)
- □ Psychiatric Evaluation
- □ Behavior Plans
- □ Mental health record
- □ Other _____

Highly CONFIDENTIAL items MUST be checked off to be EXCLUDED from this disclosure:

- □ HIV/AIDS
- □ Developmental Disabilities
- □ Drug/alcohol diagnosis, treatment
- □ Genetic testing information/records
- □ Child Abuse
- □ Sexual Assault
- □ Pregnancy

The purpose(s) of this authorization is (are):_____

This authorization expires (date):_____. If not specified, this release will expire 1 year after the date of signature (date):_____.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize **Family Care Associates** to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent:_____

Signature of patient or legal guardian, or authorized agent:_____
Date:_____ **Relationship to patient:**_____
Staff signature:_____ **Date:**_____