HEALTH & WELLNESS Center

PATIENT REGISTRATION FORM

☐ I'll review the Welcome Packet online at www.thwcinc.com **OR** ☐ I'd like a copy of the Welcome Packet to review while waiting

Section I — Demographic Information

☐ I want Online Access to my Medical Records

__________-________-___________
SSN

For Office Use Only

_____/_____/______			
Date	**Assgn Provider #**	**Intergy Patient ID**	**Explained W.P.**

Legal First Name	**MI**	**Last**	**Preferred Name/Nickname**	**Suffix**

Birth Sex: ☐ Male ☐ Female

Gender Identity (18+): ☐ Male ☐ Female ☐ Declined ☐ Transgender Male (FtoM) ☐ Other ☐ Transgender Female (MtoF)

Sexual Orientation (18+): ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Declined

DOB: _____/_____/______

Marital Status: ☐ Single ☐ Divorced ☐ Legally Separated ☐ Married ☐ Widowed ☐ Unknown

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Subcontinent Asian American ☐ Native Hawaiian ☐ Other Race ☐ More than 1 Race

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Primary Language Spoken: ☐ English ☐ Spanish ☐ Asian ☐ Other ☐ Sign Language

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Student ☐ Self ☐ Retired

Address	**Zip Code** *(City & State are determined by Zip)*

	( ) -	( ) -	
Email Address	**Home Phone**	**Work Phone**	**Ext**

(   )   -
Mobile Phone

Preferred Phone #: ☐ Home ☐ Mobile

Preferred Apt. Reminder Method (select all that apply): ☐ Voice ☐ E-Mail ☐ Text ☐ No Contact

Referral Source: ☐ HWC Employee ☐ Referring Provider ☐ Friend ☐ Referral Service ☐ Walk-In ☐ Yellow Pages ☐ Newspaper ☐ Other: ______________________

Primary Care Provider (if not Health & Wellness)

Section II — Guarantor (Financial Responsible Individual)

☐ Patient is Guarantor (no need to complete the rest of this section) ☐ Person ☐ Company

Patients Relation to Guarantor: ☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Self ☐ Employee ☐ Aunt ☐ Special Dependent ☐ Uncle ☐ Grandchild ☐ Niece/Nephew ☐ Other

__________-________-___________
SSN

First	**Middle**	**Last**	**Suffix**

Sex: ☐ Male ☐ Female

DOB: ______/______/_______

Marital Status: ☐ Single ☐ Divorced ☐ Legally Separated ☐ Married ☐ Widowed ☐ Unknown

Race (check all that apply): ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Subcontinent Asian American ☐ Native Hawaiian ☐ Other Race ☐ More than 1 Race

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ☐ Sign Language

E-Mail	**Address**

City	**State**	**Zip**

( ) -	( ) -		( ) -
Home Phone	**Work Phone**	**Ext**	**Cell Phone**

Section III — Family Income and Shelter Information (Sliding Fee)

*We require income on all patients for governmental reporting purposes

☐Weekly ☐Bi-Weekly ☐Monthly ☐Semi-Monthly ☐Quarterly ☐Annually	$	
Income Period	**Gross Income (for the period)**	**# Supported**

** To qualify for a Sliding Fee, patients must provide documented proof of income (W2; Pay Stub; Tax Return; Letter from Non-Household)
You have 30 days from the date of visit to turn in Proof of Income. Undocumented proof of income visits will be at 100% patient responsibility or insurance if applicable.

☐Homeless Shelter ☐Transitional ☐Doubling Up ☐Street ☐Not Homeless ☐Unknown ☐Other	☐Migrant ☐Seasonal ☐Not Migrant	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Homeless Status	**Worker Status**	**Public Housing**	**Veteran**	**Disabled**

Section IV — Patient Insurance Information

***Plan I** -- PLEASE SUPPLY REGISTRATION WITH A COPY OF THE CARD*

Subscriber Plan I

				$
Insurance Company	**Group Number**	**Authorize Payment**	**Claim Member ID**	**Copay**

☐ Use Patient (no need to complete the rest of this plan)	☐Child ☐Wife ☐Husband ☐Parent ☐Self ☐Employee ☐Aunt ☐Special Dependent ☐Uncle ☐Grandchild ☐Niece/Nephew ☐Other	___-___-___
	Patients Relation to Subscriber	**Subscriber SSN**

				☐ Male ☐ Female	___/___/___
Subscriber First	**MI**	**Subscriber Last**	**Suffix**	**Subscriber Sex**	***Subscriber DOB**

***Plan II** -- PLEASE SUPPLY REGISTRATION WITH A COPY OF THE CARD*

Subscriber Plan II

				$
Insurance Company	**Group Number**	**Authorize Payment**	**Claim Member ID**	**Copay**

☐ Use Patient (no need to complete the rest of this plan)	☐Child ☐Wife ☐Husband ☐Parent ☐Self ☐Employee ☐Aunt ☐Special Dependent ☐Uncle ☐Grandchild ☐Niece/Nephew ☐Other	___-___-___
	Patients Relation to Subscriber	**Subscriber SSN**

				☐ Male ☐ Female	___/___/___
Subscriber First	**MI**	**Subscriber Last**	**Suffix**	**Subscriber Sex**	***Subscriber DOB**

Section V — Emergency Contact

☐ Use Guarantor (no need to complete the rest of this plan)	☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Self ☐ Employee ☐ Aunt ☐ Special Dependent ☐ Uncle ☐ Grandchild ☐ Niece/Nephew ☐ Other	___-___-___
	Patients Relation to Subscriber	**SSN**

				☐Male ☐Female	☐English ☐Spanish ☐Sign Language ☐Other
First	**MI**	**Last**	**Suffix**	**Sex**	**Primary Language Spoken**

( ) -	( ) -		( ) -	___/___/___
Home Phone	**Work Phone**	**Ext**	**Cell Phone**	**DOB**

Section VI — Parent/Guardian (if applicable)

☐ Use Guarantor (no need to complete the rest of this plan)	☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Self ☐ Employee ☐ Aunt ☐ Special Dependent ☐ Uncle ☐ Grandchild ☐ Niece/Nephew ☐ Other	___-___-___
	Patients Relation to Subscriber	**Subscriber SSN**

				☐Male ☐Female	☐English ☐Spanish ☐Sign Language ☐Other
First	**MI**	**Last**	**Suffix**	**Sex**	**Primary Language Spoken**

( ) -	( ) -		( ) -	___/___/___
Home Phone	**Work Phone**	**Ext**	**Cell Phone**	**DOB**

Section VII — Preferred Pharmacy

		( ) -	
Preferred Pharmacy Name	**City**	**Phone**	**Mothers Maiden Name (if patient is under 19) First & Last Name Please**

ACKNOWLEDGMENT OF RECEIPT OF HWC WELCOME PACKET

Please initial beside each item that you have received in writing and understand the items contained in the welcome packet. If you at any time have questions please ask for assistance from our registration employees.

_____ Billing, Payment, and Referral Information and Registration

_____ Patient Rights and Responsibilities

_____ Consumer Notice of Health Information Practices (HIPAA)

_____ Medication Policy and Contract

_____ Discount Drug Program and Refill Information

_____ Notice of Privacy Practice

_____ Patient Centered Medical Home Agreement

____ ____________________

Patient or Patient's Representative Signature Date

____ ________________________________

Please Print Your Name Patient's Name

____

Representative's Relationship to Patient

For Office Use only

Providers have agreed for Registration to sign off on Medical Home Agreement.

____ Patient # _______________

Verification Signature

____

Date

PATIENT'S CONSENT TO TREATMENT/FOLLOW-UP FOR ALL SERVICES PROVIDED BY ALL HEALTH AND WELLNESS CENTERS

Date: ________________________________ Time: _______________________

1. I, ____, (the) ___________________________
(Name of person giving consent) (Relationship, IF other than patient)
of the hereinbefore named person, hereby consent to agreed upon outpatient care, diagnostic procedures, examinations, and medical treatment, including (but not limited to): routine laboratory work (such as blood, urine, and other studies), EKGs, and administrations of medications prescribed by the provider, if applicable. Also, if applicable, consent is given for mental health services to be provided by the means of family, group, and/or individual therapy, and to follow-up treatment after discharge.

2. I further consent to agreed upon to the performance of minor surgery, mole removal, suturing of lacerations, photographs or x-rays necessary for diagnoses and education purposes, immunizations and/or screening exams (including PPD test, influenza, Pneumococcal) for my child or myself, if applicable. I understand only appropriately trained personnel will do these procedures.

3. I acknowledge that I have the right to refuse provider recommended examination and treatment. I further acknowledge that such declination may be considered against medical advice.

4. RELEASE OF INFORMATION: I authorize HWC to release medical information regarding my health & immunization records to other Health Care Providers, Schools, Day Care, DHS, and all insurance companies including Medicare/Medicaid. This consent will also be used for payment of insurance claims. Further, I agree to pay the balance not covered by insurance in the manner agreed upon at the time of my income review.

5. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.

6. **I understand that this consent form will be valid and remain in effect as long as I use this clinic or until revoked in writing.**

7. I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Health and Wellness Center's Welcome Packet (available in both hard copy and at our website). This document includes:

a. Billing, Payment and Referral information and Registration
b. Patient Rights & Responsibilities
c. Consumer Notice of Health Information Practices (HIPAA)
d. Medication Policy and Contract
e. Discount Drug Program and Refill Information
f. Notice of Privacy Practice - A complete description of how your medical information will be used and disclosed by this facility
g. Patient Centered Medical Home (PCMH) Agreement

8. It is The Health and Wellness Center's policy to provide forms and information to patients wishing to complete an Advance Directive or a Do Not Resuscitate Order. These forms are available upon request.

a. Do you have an existing "Advance Directive"?
b. _____ Yes _____ No (If yes, please furnish a copy to HWC medical records)
c. Do you have an existing "Do Not Resuscitate Order"?

d. _____ Yes _____ No (if yes, please furnish a copy to HWC medical records)

PLEASE INITIAL ONE OF THE FOLLOWING:

e. I don't want information regarding Advance Directives/Do Not Resuscitate Orders _____

f. I do want information on Advanced Directives/Do Not Resuscitate Orders _____

If applicable:

1. I understand that the Health &Wellness Center Behavioral Health Department does not take emergency or after-hour calls. Access to the Health and Wellness Center Behavioral Health Professional staff is by appointment only. I agree to contact local emergency personnel (i.e. 911, police, ambulance, etc.) if I feel I may hurt myself or someone else, or in the event of any physical, psychological or other emergency.
2. I agree not to access with a Release of Information form session notes, CAR scores or any other documents that contain clinical opinion in order to protect the disclosures and substantiating records that pertain to my child to protect that information from any non-therapeutic intent.
3. I understand that Stigler Health &Wellness Center, Inc. therapists do not testify in court regarding custody or divorce actions. It has been explained to me that custody evaluations and expert testimony require a specific procedure and relationship with the client that is different from a therapeutic relationship. It is in fact, unethical for the therapist to move from a therapist's role to one of advising the court regarding the fitness of a parent or the child's needs concerning who would be the "best" parent. I understand that should the need arise for this type of evaluation and testimony, Stigler Health & Wellness Center, Inc. will be happy to refer me to independent psychologists that Health & Wellness Center Behavioral Health Department has found to be experts in this area of service. I also understand that a minimum fee of $1,500 per half day or less out of the office will be assessed to my account should Health & Wellness Center Behavioral Health Department staff be legally required to testify in any court proceeding on my behalf.

____	____
Patient or Patient's Representative Signature	Representative's Relationship to Patient
____	____
Please Print Your Name	Patient's Name

____

Verification signature

Providers have agreed for Health Care Designee to sign off on Medical Home Agreement.

For Office Use only

Patient # _______________

CONSENT OF PROTECTED HEALTH INFORMATION

The information authorized for release may include information which may indicate the presence of a communicable or non-communicable disease. I understand that the information requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse Patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA'), 45 C.F.R. Parts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulations. I understand that treatment services are NOT contingent upon or influenced by my decision to permit the release of information. I further understand that if the organization or person authorized to receive this information is not required to comply with the Federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

Please identify the person or persons you authorize your Protected Health Information (oral or recorded information) to be released to by Stigler Health and Wellness Center, Inc. (SHWC).

This may include your spouse, parents, siblings, children, friends or guardian. Please list below:

NAME	RELATIONSHIP	HOME PHONE #	CELL PHONE #

Stigler Health and Wellness Center, Inc. is required to have your permission to leave messages regarding your Protected Health Information (test results, instructions, appointment reminders, etc.)

Please check the appropriate boxes:

_________________ **Yes,** SHWC **may** leave a message on my answering machine/voice mail regarding my Protected Health Information.

Comments: ____

_________________ **No,** SHWC **may not** leave a message on my answering machine/voice mail regarding my Protected Health Information

____ ______________________________

Signature Date

____ ______________________________

Printed Name Relationship to Patient

___________________________ ____

Patient # Patient Name

This authorization shall remain in effect until revoked.

____

Dental Health History Update **Date:**_____/_____/_____

Name:___________________________________ **DOB:**_____/_____/_____ **Age:**_____ **Chief Complaint:**_________
Last, First, M.I.

Past Medical History: Please mark **(X)** if **YOU** have **ANY** of the following:

__ Arthritis
__ Artificial bone/joints **Physician**:_________________________
__ Artificial heart valve/stents **Physician**:____________________
__ Asthma
__ Bleeding/Clotting Disorder
__ Blood Transfusion **Date**:_____________
__ Cancer/Chemotherapy **Physician**:______________________
__ Chronic Lung Disease/Difficulty Breathing
__ Diabetes
__ Disease of stomach/liver/colon/pancreas
__ Epilepsy/Seizures
__ Heart Attack/Heart Disease
__ Hepatitis (Type)_____
__ High Blood Pressure
__HIV+/AIDS

__ Kidney/Bladder Problems
__ Pregnant Due Date:_____/_____/_____
__ Psychiatric Problems
__ Rheumatic Fever
__ Stroke
__ Reaction to anesthetic
__ Any use of IV/Oral bisphosphonates
__ Other:_______________________________

ALLERGIES:

__ Aspirin
__ Codeine
__ Erythromycin
__ Latex
__ Penicillin
__ Tetracycline

Other:_____________
____
____
____
____
____

Current Medications: Name, Dose, Frequency and Use

________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________

Previous Blood Transfusions: Y N When?____

Past Surgeries/Hospitalizations:

Date Reason

__________ ____
__________ ____
__________ ____

Habits: **Smoking**: Y N (__ packs/day) **Smokeless Tobacco**: Y N **Caffeine**: Y N
Alcohol: None Occas. Mod. Heavy **Past/Present Drug Use**: Y N

Family History: Please mark **(X)** if any of your immediate family has any of the following:
e.g. Parents, Siblings, Grandparents, Etc.

__ Arthritis
__ Bleeding/Clotting Disorder
__ Cancer
__ Chronic Lung Disease
__ Diabetes
__ Disease of Bladder/Urinary Tract

__ Disease of Stomach/Liver/Colon/Pancreas
__ Heart Disease
__ High Blood Pressure
__ Psychiatric
__ Seizures/Epilepsy
__ Stroke

If patient requires an antibiotic prior to treatment please circle: PRE-MED

Patient Signature:____ Reviewed by:_____________________________

Notice of Patient Responsibility for Payment for Dental Services

Dear Dental Patients,

The Health and Wellness Center dental Clinic is not a free clinic. In order to continue providing quality services and maintain the financial viability of our dental program, Sliding Scale/Self-Pay Patients are responsible for the following:

1. Pay their remaining balances in full prior to receiving further non-emergent care. If your existing balance is not paid in full, we will not be able to continue elective care and you will be rescheduled.
2. Payment is due in full at the time of your visit.
3. For all major dental work (dentures, crowns, and root canals), 50% of the fee will be required before the first appointment can be scheduled. The remaining 50% balance must be paid at the time the denture(s), crown(s), or root canal(s) are started. Patients will be alerted when payments are due so that they can bring the proper funds to the dental visit.
4. Understanding that not all services offered by the Health & Wellness Center Dental Department are included in the Sliding Fee list of services. The patient should discuss this with the dental staff so that they are fully aware of their payment responsibilities.
5. No one with a dental emergency will be denied services, regardless of their ability to pay; however, payment is indeed recommended at time of the emergency service. Elective/follow-up work relevant to the emergency visit will not be started until all outstanding balances are paid in full.

____ ______________________

Patient/Parent/Guardian Signature Date

____

Patient Name (Printed)

____

Patient Number

The Health and Wellness Center - Dental Clinic
Missed Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care. Our policy requires:

- Appointment Confirmation: **You will receive a courtesy confirmation call and if you receive a message, you must personally call back to confirm your appointment.** It is your responsibility. If you do not call to confirm, we will cancel your appointment and consider your appointment a: missed appointment.

Initials: __________

- Timely Cancelations: If you need to cancel or reschedule your appointment, **you must call us at least the day before.** Cancelations made on the day of your appointment will be considered a missed appointment.

Initials: __________

- On Time Arrivals: If you are more than 15 minutes late to your appointment, we will not cancel the appointment instead: it will be counted as No-Show and patient will be counted as a walk-in. We will try to see you before the end of the clinical session.

Initials: __________

- Compliance: Patients are only allowed two missed appointments in a 6 month period. After the second missed appointment, you will not be scheduled appointments, but are welcome to use the dental clinic as a "walk-in" or an "open-access" patient.

Initials: __________

Many patients use The Health and Wellness Dental Clinic services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

____________________________________ ________________________

Patient or Parent/Guardian Signature **Date**

__________________________________ ______________________

Patient Name (Printed) Patient Number