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

For Office Use Only

SSN	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 #	Preferred Apt. Reminder Method (select all that apply)
( ) -	☐ Home ☐ Mobile	☐ 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. <u>THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.</u>
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.