

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							
<input type="checkbox"/> 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			
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Transgender Male (FtoM) <input type="checkbox"/> Transgender Female (MtoF)		<input type="checkbox"/> Female <input type="checkbox"/> Declined <input type="checkbox"/> Other		<input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Declined			DOB				
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown			<input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> More than 1 Race			<input type="checkbox"/> Native American <input type="checkbox"/> Subcontinent Asian American <input type="checkbox"/> Native Hawaiian			Race			
<input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Latino/Hispanic <input type="checkbox"/> Not Reported/Refused			<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Sign Language		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Self <input type="checkbox"/> Retired			Employment Status				
Address							Zip Code <i>(City & State are determined by Zip)</i>					
Email Address				Home Phone		Work Phone		Ext				
Mobile Phone				<input type="checkbox"/> Home <input type="checkbox"/> Mobile Preferred Phone #		<input type="checkbox"/> Voice <input type="checkbox"/> Text <input type="checkbox"/> E-Mail <input type="checkbox"/> No Contact		Preferred Apt. Reminder Method <i>(select all that apply)</i>				
<input type="checkbox"/> HWC Employee <input type="checkbox"/> Referring Provider <input type="checkbox"/> Referral Service <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Other: _____						<input type="checkbox"/> Friend <input type="checkbox"/> Walk-In		Primary Care Provider (if not Health & Wellness)				
Referral Source												

Section II					Guarantor (Financial Responsible Individual)							
<input type="checkbox"/> Patient is Guarantor (no need to complete the rest of this section)					<input type="checkbox"/> Person <input type="checkbox"/> Company							
<input type="checkbox"/> Child <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Aunt <input type="checkbox"/> Special Dependent <input type="checkbox"/> Uncle <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Other				SSN								
Patients Relation to Guarantor				First		Middle		Last		Suffix		
<input type="checkbox"/> Male <input type="checkbox"/> Female		DOB		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown		Marital Status						
<input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Subcontinent Asian American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Race <input type="checkbox"/> More than 1 Race						<input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Latino/Hispanic <input type="checkbox"/> Not Reported/Refused						
Race (check all that apply)						Ethnicity						
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Sign Language			Primary Language Spoken			E-Mail			Address			
City				State				Zip				
Home Phone			Work Phone			Ext		Cell Phone				

Family Income and Shelter Information (Sliding Fee)

*We require income on all patients for governmental reporting purposes

Section III

<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> 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.								
<input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Street <input type="checkbox"/> Not Homeless <input type="checkbox"/> Unknown <input type="checkbox"/> Other Homeless Status	<input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Not Migrant Worker Status	<table style="width: 100%;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 25%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 25%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Public Housing</td> <td>Veteran</td> <td>Disabled</td> </tr> </table>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Public Housing	Veteran	Disabled
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Public Housing	Veteran	Disabled						

Section IV

Patient Insurance Information

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

_____ Insurance Company	_____ Group Number	_____ Authorize Payment	_____ Claim Member ID	\$ _____ Copay
<input type="checkbox"/> Use Patient (no need to complete the rest of this plan)	<input type="checkbox"/> Child <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Aunt <input type="checkbox"/> Special Dependent <input type="checkbox"/> Uncle <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Other Patients Relation to Subscriber			_____ - _____ - _____ Subscriber SSN
_____ Subscriber First	_____ MI	_____ Subscriber Last	_____ Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female Subscriber Sex
				____/____/____ *Subscriber DOB

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

_____ Insurance Company	_____ Group Number	_____ Authorize Payment	_____ Claim Member ID	\$ _____ Copay
<input type="checkbox"/> Use Patient (no need to complete the rest of this plan)	<input type="checkbox"/> Child <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Aunt <input type="checkbox"/> Special Dependent <input type="checkbox"/> Uncle <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Other Patients Relation to Subscriber			_____ - _____ - _____ Subscriber SSN
_____ Subscriber First	_____ MI	_____ Subscriber Last	_____ Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female Subscriber Sex
				____/____/____ *Subscriber DOB

Section V

Emergency Contact

<input type="checkbox"/> Use Guarantor (no need to complete the rest of this plan)	<input type="checkbox"/> Child <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Aunt <input type="checkbox"/> Special Dependent <input type="checkbox"/> Uncle <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Other Patients Relation to Subscriber			_____ - _____ - _____ SSN
_____ First	_____ MI	_____ Last	_____ Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female Sex
				<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other Primary Language Spoken
() - Home Phone	() - Work Phone	_____ Ext	() - Cell Phone	____/____/____ DOB

Section VI

Parent/Guardian (if applicable)

<input type="checkbox"/> Use Guarantor (no need to complete the rest of this plan)	<input type="checkbox"/> Child <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Aunt <input type="checkbox"/> Special Dependent <input type="checkbox"/> Uncle <input type="checkbox"/> Grandchild <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Other Patients Relation to Subscriber			_____ - _____ - _____ Subscriber SSN
_____ First	_____ MI	_____ Last	_____ Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female Sex
				<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other 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
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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.

Verification Signature

Patient # _____

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 to 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 Notice of Privacy Practice. A complete description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES. A copy is included in your Welcome Packet and is made available in the clinic.

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.

9. Do you have an existing "Advance Directive"?

10. ____ Yes ____ No (If yes, please furnish a copy to HWC medical records)

11. Do you have an existing "Do Not Resuscitate Order"?

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

PLEASE INITIAL ONE OF THE FOLLOWING:

13. I don't want information regarding Advance Directives/Do Not Resuscitate Orders ____

14. 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

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:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney/Bladder Problems |
| <input type="checkbox"/> Artificial bone/joints Physician: _____ | <input type="checkbox"/> Pregnant Due Date: ___/___/___ |
| <input type="checkbox"/> Artificial heart valve/stents Physician: _____ | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion Date: _____ | <input type="checkbox"/> Reaction to anesthetic |
| <input type="checkbox"/> Cancer/Chemotherapy Physician: _____ | <input type="checkbox"/> Any use of IV/Oral bisphosphonates |
| <input type="checkbox"/> Chronic Lung Disease/Difficulty Breathing | <input type="checkbox"/> Other: _____ |

ALLERGIES:

- | | | |
|--|---------------------------------------|--------------|
| <input type="checkbox"/> Disease of stomach/liver/colon/pancreas | <input type="checkbox"/> Aspirin | Other: _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Erythromycin | _____ |
| <input type="checkbox"/> Hepatitis (Type) _____ | <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Tetracycline | _____ |

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.

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Disease of Stomach/Liver/Colon/Pancreas |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Disease of Bladder/Urinary Tract | <input type="checkbox"/> 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 Cancellations: If you need to cancel or reschedule your appointment, **you must call us at least the day before.** Cancellations 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 give your appointment away to another patient. This will be considered a missed appointment.

Initials: _____

- Compliance: Patients are only allowed TWO missed appointments in a 12 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