

### PATIENT REGISTRATION FORM

I'll review the Welcome Packet online at [www.thwcinc.com](http://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 &amp; 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"/> Friend <input type="checkbox"/> Walk-In <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Other: _____						Referral Source					Primary Care Provider (if not Health & Wellness)				

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					Patients Relation to Guarantor					SSN: _____									
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					Race (check all that apply)					<input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Latino/Hispanic <input type="checkbox"/> Not Reported/Refused					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 <b>Income Period</b>	\$ _____ <b>Gross Income (for the period)</b>	_____ <b># Supported</b>
** 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 <b>Homeless Status</b>	<input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Not Migrant <b>Worker Status</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Public Housing   Veteran   Disabled</b>

#### 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	\$	Coplay	
	<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 <b>Patients Relation to Subscriber</b>		_____ - _____ - _____ <b>Subscriber SSN</b>
	Subscriber First	MI	Subscriber Last	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female <b>Subscriber Sex</b>	____/____/____ <b>*Subscriber DOB</b>	

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

Subscriber Plan II	Insurance Company	Group Number	Authorize Payment	Claim Member ID	\$	Coplay	
	<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 <b>Patients Relation to Subscriber</b>		_____ - _____ - _____ <b>Subscriber SSN</b>
	Subscriber First	MI	Subscriber Last	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female <b>Subscriber Sex</b>	____/____/____ <b>*Subscriber DOB</b>	

#### 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 <b>Patients Relation to Subscriber</b>				_____ - _____ - _____ <b>SSN</b>	
First	MI	Last	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female <b>Sex</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other <b>Primary Language Spoken</b>	
(   )   -	(   )   -	(   )   -	(   )   -	____/____/____ <b>DOB</b>		
<b>Home Phone</b>	<b>Work Phone</b>	<b>Ext</b>	<b>Cell Phone</b>			

#### 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 <b>Patients Relation to Subscriber</b>				_____ - _____ - _____ <b>Subscriber SSN</b>	
First	MI	Last	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female <b>Sex</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other <b>Primary Language Spoken</b>	
(   )   -	(   )   -	(   )   -	(   )   -	____/____/____ <b>DOB</b>		
<b>Home Phone</b>	<b>Work Phone</b>	<b>Ext</b>	<b>Cell Phone</b>			

#### 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.

\_\_\_\_\_  
Verification Signature

Patient # \_\_\_\_\_

\_\_\_\_\_  
Date



**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.**



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

Date: \_\_\_\_\_

Time: \_\_\_\_\_

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**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 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 # \_\_\_\_\_

Stigler Health & Wellness Center, Inc.

Patient Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_ Patient #: \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

Add Totals Together \_\_\_\_\_

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all   
  Somewhat difficult   
  Very difficult   
  Extremely difficult

# Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number \_\_\_\_\_

Score \_\_\_\_\_

## INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____