Health Rx Wellness

Dr. Christopher Hancock | Kristina Doolittle, APRN | Jayme Taylor, APRN, CSOWM

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____

Email Address: _____ Social Security Number: _____

Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer
Choose not to disclose Other gender category not listed

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

Employment Information

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy and Labs

Preferred Pharmacy: _____

Address: _____ Phone: _____

Preferred Lab: _____

Address: _____ Phone: _____

Insurance

Primary Insurance: _____

Secondary Insurance: _____

Please present your insurance card to staff at the front desk.

RX HEALTH & WELLNESS PATIENT AGREEMENT

Authorization for Medical Treatment

Office Practice/Clinic personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, and to record, film and/or photograph for treatment, performance improvement or education, deemed necessary or advisable until the update patient agreement is signed or this form is revoked by me or my representative. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

Disclosure of Information

I understand that my medical records and billing information are made and retained by this office and are accessible to office personnel. Office personnel may use or disclose medical information for operations, functions and to any other physician or health care personnel involved in continuum of care. Safeguards are in place to ensure improper access. This office and its medical staff are authorized to disclose all or part of my medical record to insurance carrier, workers compensation carrier, or self-insured employer group liable for any of the office charges and to any health care provider who is or may be involved in my care. Oklahoma/Kansas law requires that this office advise you that information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Office personnel may release my general condition to family/friends that inquire about me by name.

Assignment of Insurance Benefits

I agree that physician benefits otherwise payable to the insured are to be made payable to the providers responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to rules of coordination of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash or credit card at the time of service.

Precertification Policy

I understand that the office will assist with precertification requirements but will NOT assume responsibility for any precertification or any impact which it may have on insurance payment.

Financial Responsibility

As consideration for services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this office.

Certification

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this patient agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this patient agreement. A photocopy of this agreement has the same effect as an original.

Patient or Representative	Relationship to Patient	Date Signed	Witness

Patient Name- Printed	Date of Birth	Account Number

Release of Protected Health Information

Information may be released to the following individual(s)

Name/Relationship	Phone Number	Name/Relationship	Phone Number

Acknowledgment of Notice of Privacy Practices

A complete description of how your medical information will be used and disclosed by this office is in our Notice of Privacy Practices, which is available to you upon request. A copy is also posted inside the office.

I have received a copy of Notice of Privacy Practices

Patient or Representative	Relationship to Patient	Date Signed	Witness

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: (First) _____ (Last) _____
Date of birth: _____/_____/_____ SSN: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.* 2. *The following individual or organization is authorized to make the disclosure.*

Practice Name: _____
Address: _____ (City) _____ (State) _____ (Zip) _____

1. The type and amount of information to be used or disclosed is as follows:

□ Complete health records □ Lab results/X-ray reports

□ Physical exam □ Consultation reports

□ Immunization record □ Other (please specify): _____

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. *This information may be disclosed to and used by Rx Health & Wellness for the purpose of* _____

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

4. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Rx Health & Wellness.

_____ _____

Patient's Name (printed) Date

_____

Patient Signature *(or signature of person with authority to consent for patient)*

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NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____ Phone:
(Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____ Pharmacy: _____

Medication/Allergy History

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

_____ _____ _____ _____

_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

System Review (Check all that apply)

▢ Recent Weight loss more than 10lbs		▢ Recent Weight gain more than 10lb	
▢ Acne	▢ Constipation	▢ Cough	▢ Chest pain
▢ Skin rash	▢ Abdominal pain	▢ Snoring	▢ Palpitations
▢ Anxiety	▢ Diarrhea	▢ Difficulty breathing when flat	▢ Fainting/Blacking out
▢ Depression	▢ Indigestion	▢ Shortness of breath	▢ Swelling ankles/extremities
▢ Inability to concentrate	▢ Increased appetite	▢ Difficulty swallowing	▢ Dizziness
▢ Loss of interest	▢ Decreased appetite	▢ Weakness/low energy	▢ Seizures
▢ Mood changes	▢ Food intolerance	▢ Urinary frequency/urgency	▢ Headache
▢ Insomnia	▢ Nausea/vomiting	▢ Nighttime urination	▢ Back pain
▢ Memory loss	▢ Gas and bloating	▢ Slow urine flow	▢ Muscle aches/pain
▢ Cold/heat intolerance	▢ Blood in stool	▢ Joint pain	▢ Blood clots

Family History

Other (check all that apply):	▢ High Blood Pressure	▢ Heart Disease	▢ High Cholesterol
▢ High Triglycerides	▢ Stroke	▢ Thyroid Problems	▢ Anxiety
▢ Diabetes	▢ Depression	▢ Bipolar Disorder	
▢ Cancer (type/s):_____		▢ Other:_____	

Social History

Smoking: □ Never □ Current smoker (_____ packs/day) □ Past smoker (quit _____ years ago)
Alcohol: □ Never □ Occasional □ Regularly (_____ drinks per day) Prior treatment for alcoholism? Y / N
Drugs: □ Never □ Current □ Past □ Type of drugs: _____
Marijuana: □ Never □ Current user (_____ times/day)
Marital Status: _____

Medical History

Exercise type:_____ Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising? _____
How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

▢ Heart Attack	▢ Angina	▢ Gallbladder Stones	▢ Sleep Apnea
▢ High Blood Pressure	▢ Stroke	▢ Indigestion/Reflux	▢ Thyroid
▢ High Cholesterol	▢ Diabetes	▢ Celiac Disease	▢ Anxiety
▢ High Triglycerides	▢Gout	▢ Pancreatitis	▢ Depression
▢ Infertility	▢ Arthritis	▢ PCOS	▢ Bipolar
▢ Glaucoma	▢ Cancer (type/s): _____		

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

▢ Gastric Bypass	▢ Gastric Banding	▢ Gastric Sleeve	▢ Gallbladder
▢ Heart Bypass	▢ Hysterectomy	▢ Other: _____	

Gynecologic History

Age periods started? _____ Age periods ended _____ Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____ Age of first pregnancy: _____ Age of last pregnancy: _____

▢ Absence of periods	▢ Hot flashes	▢ Change in bladder habits
▢ Facial hair	▢ Abnormal/excessive menstruation	

Comments: _____
_____
_____

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Rx Health & Wellness No-Show Policy Statement

Due to the limited spaces available on each provider schedule it is necessary that patients that are scheduled show up at their designated times. Patients have until 24 hours prior to their appointment time to cancel their appointment. We do understand that things happen and therefore in some cases we will overlook same day reschedules, unless these become a pattern for patients. Each appointment that is scheduled and no-showed is an appointment that could have been utilized by another patient. Therefore, our policy is that patients that no-show their appointments will be charged a no-show fee of $60 as reimbursement for the visit that they missed. This will be billed to the credit/debit/HSA card on file for that patient. Signing this agreement verifies that you understand this policy and your responsibility as the patient to cancel your appointment in a timely fashion should you not be able to make it to your scheduled appointment. Furthermore, patients that are more than 10 minutes late for their appointment will be considered no-shows, unless otherwise approved by the clinic.

I,_____ have read the above policy statement and agree to cancel all scheduled appointments prior to 24 hours of the appointment time. Additionally, I understand that should I no-show my appointment that I am responsible for the total visit cost of that appointment which is equal to $60. In which case, I give permission for Rx Health & Wellness to debit the card on file for this fee.

_____ _____

Patient / Representative Signature Date

_____ _____

Witness Signature Date