



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 PEDIATRIC MEDICAL HISTORY FORM

Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_
Name you prefer to be called: \_\_\_\_\_
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_
Phone: (Home/Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ Gender: M / F
Referred By: \_\_\_\_\_ Pharmacy: \_\_\_\_\_
Pediatrician: \_\_\_\_\_ SSN: \_\_\_\_\_

How does your weight affect your life and health? \_\_\_\_\_

Nutritional History

How often do you eat breakfast? \_\_\_\_ days per week at \_\_\_\_:\_\_\_\_ a.m.
Number of times you eat per day: \_\_\_\_ What beverages do you drink? \_\_\_\_\_
Do you get up at night to eat? Y / N If so, how often? \_\_\_\_ times
List any food intolerances/restrictions: \_\_\_\_\_

Food triggers (check all that apply):

- Stress Boredom Anger Insomnia Seeking Reward
Parties Eating Out Other: \_\_\_\_\_

Food cravings (check all that apply):

- Sugar Chocolate Starches Salty Fast Food
High Fat Large Portions : \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Medication History

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

\_\_\_\_\_

Allergy History

(Medications) \_\_\_\_\_
(Food) \_\_\_\_\_

Vaccine History

Are you up to date on all vaccinations? YES NO

**System Review** (Current concerns)

- Recent Weight loss more than 10lbs  Recent Weight gain more than 10lb

Head: \_\_\_\_\_

Chest: \_\_\_\_\_

Stomach: \_\_\_\_\_

Skin: \_\_\_\_\_

Muscles: \_\_\_\_\_

Joints/Bones: \_\_\_\_\_

Psychiatric: \_\_\_\_\_

**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**

History of behavior problems?  YES  NO. If YES please describe: \_\_\_\_\_

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 drug type: \_\_\_\_\_

Marijuana:  Never  Current User (\_\_\_\_\_ times/day)

**Medical History**

Activity 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? \_\_\_\_\_

How many hours are spent in front of a screen?

Past medical history (check all that apply):

- ADD/ADHD
- Abuse/Domestic Violence
- Allergies/Hay Fever
- Anemia
- Anxiety Disorder
- Asthma
- Autism
- Bedwetting
- Birth Defects
- Bladder/Kidney Problems
- Blood Diseases
- Blood Transfusion
- Breast Problems
- Chicken Pox
- Chronic Ear Infections
- Constipation
- Coronary Artery Disease
- Depression
- Developmental Disorders
- Diabetes
- Difficulty Swallowing
- Diverticulitis
- Ear or Hearing Problems
- Cancer (type/s): \_\_\_\_\_
- Eczema
- Endometriosis
- GI Problems
- Gout
- Headaches
- Heart Problems
- High Cholesterol
- Hypertension
- Kidney stones
- Liver Disease
- Lung Disease
- MRSA Exposure
- Mental Disorder
- Muscle/Joint Problems
- Obesity
- Pulmonary Embolism
- Reflux/GERD
- Seizures/Epilepsy
- Skin Problems
- Thrombophilias
- Thyroid Disorder
- Vision/Eye Problems

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

Past surgical history (check all that apply):

- Tonsil
- Adenoids
- Ear Tubes
- Other: \_\_\_\_\_
- Appendix
- Gallbladder

**Gynecologic History**

Age periods started? \_\_\_\_\_ Periods are: Regular / Irregular Heavy / Normal / Light

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

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