PRIVACY NOTICE
ROBIN WEST, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

- As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment and the health care operations.

- You may revoke this consent at any time by notifying our office in writing, except to the extent our office has acted action on your consent.

- Please refer to the “Privacy Notice” posted on our website or provided upon request for a full description of the uses and disclosures of your protected health information. You have the right to review the “Privacy Notice” prior to signing this consent.

- Our office has reserved the right to change its privacy practices describe in the “Privacy Notice”. You may request a current copy of the “Privacy Notice” in writing or in person.

- You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations; however, our office is not required to agree to such restrictions.

I hereby consent to the use and disclosure of my protected health information by Robin West, LLC, it’s staff and its business associates for purposes of treatment, payment and health care options.

____

Signature

____

Signature of Personal Representative of Patient

____

Description of Representative’s Authority to Act for the Patient

Date: ________________

HIPAA Release Form

Authorization to Release Protected Health Information

Mail or fax completed forms to:

Family Health and Wellness 1938 NW Copper Oaks Circle 1938 NW Copper Oaks Circle Blue Springs, Missouri 64015

Fax: (816) 988-8451

Primary Client Information

Last Name:	First Name:	MI:
Street Address:	City/State:	Zip:
DOB:	Phone:	Email Address:

HIPAA Release

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearing house, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to ________________________________

Fax Number __________________________ to disclose protected health information (as defined in HIPAA) to Family Health and Wellness (FHW): Robin West ARNP FNP BC for the purpose of authorization for Continuation of Health Services.

☐ Please provide all medical records, office notes, laboratory results, radiology reports for the last two (2) years

☐ Please provide recent hospital records, to include discharge summary, radiology, laboratory reports

☐ Please provide results diagnostic study of: ________________________________

Authorization of HIPAA Release

I understand that I have the right to refuse to sign this form and that my refusal will not result in the healthcare provider conditioning the provision of declining healthcare services. I also understand that this release will allow the provider to share my medical information with insurance companies to facilitate healthcare services. I understand that I may revoke this authorization at any time by notifying FHW in writing.

Parent/Guardian Name:______________________________

Name: _____________________ Signature: ________________________ Date: _____________

Patient Registration Form

☐Mr. ☐Miss ☐Mrs. ☐Ms.

Patient's name (last) _______________ (first) _______________ (MI) ___ Previous Name _____________________

Street address ____

City/State ________________________________ ZIP _________________

Home Phone ________________ Cell No. ________________Work Phone _______________ Ext. ______

E-Mail Address ____________________________

Primary Care Provider ________________________ Referring Provider ___________________________

Date of Birth MM_____/ DD_______/ YYYY ______

Marital Status ☐Married ☐Single ☐ Divorced ☐Widowed ☐Separated ☐Partner

Social Security Number:_____-_____-_____ Employer Name ____________________________________

Employment Status ☐ Full-time☐Part-Time ☐ Not Employed ☐Self-Employed ☐Retired ☐ Active Military

Student Status ☐Full Time Student ☐ Part Time Student ☐Not a Student

Emergency contact: Last Name_________________ First Name_____________________

Phone number_________________ Do you have a living will? Yes ☐ No ☐

Emergency contact relationship to patient____________________________________ Guardian ☐

Street address____

City/State_______________________________

Home phone__________________ Cell no.___________________ Work Phone ___________________

Ext._______

Billing: Mail Statement ☐ Email Statement ☐

RESPONSIBLE PARTY INFORMATION

Responsible Party Another patient ☐ Guarantor☐ Self ☐

Responsible Party Name (Last)________ (First)__________ (MI)___________ Previous Name________________

Guarantor Account Number ___________________________ Date of Birth MM_____/ DD _____/ YYYY _______

Social Security-Number ______-______-______ Telephone _______________

E-mail address ___________________

Street address _____________________________________ City/State __________________ Zip ___________

Employer _________________________ Employer Phone Number __________________

PRIMARY INSURANCE INFORMATION

Insurance Company/Phone Number ________________ (_____) ____________

Name of insured ______________ Patients Relationship to insured__________________

Subscriber ID (Policy Number) ___________________________ Group ID _______________

Copay Amount __________

Effective Date___________ Termination Date________ Date of Birth _______________

SECONDARY INSURANCE INFORMATION

Insurance Company/Phone Number __________________ (_____) ____________

Name of insured _______________ Patients Relationship to insured__________________

Subscriber ID (Policy Number) ___________________________ Group ID _______________

Copay Amount __________

Effective Date______ Termination Date_______ Date of Birth ________________

PHARMACY

Name______________ Phone__________ Fax__________________

Street address_________________________________

City/State____________________________ ZIP________________

How did you hear about us?

____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Name_______________ Signature_____________________

Date________________

FINANCIAL AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days of your date of service, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _________________ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired during my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

FEES: There will be a $35.00 fee plus handling for the following: Electronic copy of medical records to a patient or insurance company, all documents (FMLA, Jury letters, et al.) completed by HealthCare Provider. There will be a $50.00 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check or cash). If you need to cancel a scheduled appointment, please contact our office at least 24 business hours before your appointment time. Due to high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $50.00 fee will be assessed for all missed appointments not cancelled within at least 24 business hours advance notice. All product sales are final, products are non-refundable or exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon the patient's request.

Print Name: _________________ Signature: _______________________ Date: ___________________

I authorized this facility to release information to (Please check all that apply):

☐ SPOUSE (name & phone number) ____________________________________

☐ CHILDREN (name & phone number) ___________________________________

☐ OTHER (name & phone number) _____________________________________

☐ No One

MESSAGES MAY BE LEFT AT THE FOLLOWING LOCATIONS (Check those that apply)

☐ Home ☐ Cell ☐ Work

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signature: __________________________________ Date: ___________________

Print Name: __________________________________ Title or Relationship: ___________________

Witnessed by: __________________________________ Address: ___________________

If signed by other than beneficiary, state reason the patient was unable to sign: ____________________

Medicare Patients
I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished to me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer _____________________ any information needed to determine those benefits payable for related services.

Signature: __________________________________ Date: ___________________

PAST MEDICAL HISTORY: (Check all that apply)

Name:____ Date:____________________

- ☐ Heart Disease ☐ Liver Disease ☐ Tuberculosis ☐ Heart Murmur ☐ Pneumonia ☐ Kidney Infection
- ☐ Thyroid Disease ☐ Diabetes ☐ Stroke ☐ Arthritis ☐ Emphysema ☐ High Blood Pressure
- ☐ Anxiety ☐ Parkinson's ☐ Indigestion ☐ Depression ☐ Ulcer ☐ Multiple Sclerosis

Other:____

SURGICAL HISTORY: (Check all that apply) Have you had any operations? Yes ☐ No ☐

- ☐ Appendectomy ☐ Gall Bladder ☐ Breast ☐ Laparotomy ☐ Prev. Screening ☐ Chest X-Ray
- ☐ Laparoscopy ☐ Stomach/Bowel ☐ Hernia Repair ☐ Hip ☐ Colonoscopy ☐ EKG
- ☐ Knee Surgery ☐ Spine ☐ Tonsillectomy ☐ Thyroid ☐ Mammogram ☐ EGD Bone Density
- ☐ Cancer ☐ Endometriosis ☐ Pap Smear

If you answered yes or checked any boxes above, please list the procedure and date below:

____

____

FAMILY HISTORY

Father: Alive Deceased; if so, cause_____________________ Health issues____________________________

Mother: Alive Deceased; if so, cause____________________ Health issues____________________________

Other family members with health issues?____

SOCIAL HISTORY & HEALTH HABITS

Current marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Pregnancy History: Pregnancies____ Deliveries_____ Miscarriage_______ Abortion______ Other________

Number of people living in your household__________ Current or previous occupation______________

Do you smoke? If yes, how many packs per day?__________ When did you quit?_________ Do you want to quit?______________

Do you use alcohol?_________ If yes, how many alcoholic beverages do you consume per ______day _____week ______month?

Do you use drugs? Yes ☐ No ☐

Do you exercise regularly? Yes ☐ No ☐ If yes, what type of exercise do you do?____________________________________

CREDIT CARD POLICY

I understand it is the policy of Family Health and Wellness to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with all the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier:

- The claim is denied for any reason, or the insurance company fails to respond to the claim: or
- There is patient liability (i.e. Deductible, co-insurance, copay, et. Al)

The office will send a statement notifying me of the balance due. If this amount is not paid within 15 days from claim submission, then my credit or debit card will be charged the entirety of the balance owed for services previously rendered to me or my dependent.

I understand my insurance company will provide notification of these charges with an explanation of benefits, and it is my responsibility to review my explanation of benefits. The total amount may also include but is not limited to “No Show”/”Late”/”Cancellation”/Finance charges. In the event the amount exceeds $250.00, the office will provide a courtesy call to the phone number I provided on my patient demographics, leaving a message if I cannot be reached.

I understand that in the event my credit or debit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment for those charges, the office will issue a credit to my credit or debit card.

Patient Name: ____________________________________

Type of Credit or Debit Card: ☐ Visa ☐ Mastercard ☐ Other

Name of Card Holder: ____

16 Digit Number on Card: _____________________________________

Expiration Date: ______________ Security Code: ____________ Billing Zip: _______________

I understand I am financially responsible for the medical services provided to me and my dependents and if the account Is not paid in full within 30 days, it may be turned over to a collection agency or attorney for collection, and I will be responsible for all collection fees and or legal fees to the extent allowed by applicable law. I have read, understand and agree to the financial policy.

Signature of Patient and or Responsible Party: ____________________________ Date: ___________

ALLERGIES: Do you have any allergies to medications? Yes ☐ No ☐

If yes, please list including reaction to each medication:

____

MEDICATIONS: Please list all medicines which you are currently taking (including contraceptives, hormones, vitamins and over the counter medications) Use a separate sheet if necessary.

1. Medication:____________________________ Dosage:_______________________
2. Medication:____________________________ Dosage:_______________________
3. Medication:____________________________ Dosage:_______________________
4. Medication:____________________________ Dosage:_______________________
5. Medication:____________________________ Dosage:_______________________
6. Medication:____________________________ Dosage:_______________________
7. Medication:____________________________ Dosage:_______________________
8. Medication:____________________________ Dosage:_______________________
9. Medication:____________________________ Dosage:_______________________
10. Medication:____________________________ Dosage:_______________________
11. Medication:____________________________ Dosage:_______________________
12. Medication:____________________________ Dosage:_______________________
13. Medication:____________________________ Dosage:_______________________
14. Medication:____________________________ Dosage:_______________________
15. Medication:____________________________ Dosage:_______________________
16. Medication:____________________________ Dosage:_______________________
17. Medication:____________________________ Dosage:_______________________

Review of symptom: Please check if any of the following symptoms apply

General/Constitutional
- ☐ Change in appetite
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other ___________________

Respiratory
- ☐ Cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other______________________

Genitourinary
- ☐ Vaginal discharge
- ☐ Kidney stone
- ☐ Other___________________

Allergy/Immunology
- ☐ Hives
- ☐ Hay fever
- ☐ Other

Breast
- ☐ Breast Lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Other_____________________

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Painful joints
- ☐ Other_____________________

Ophthalmologic
- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Pain
- ☐ Other_______________

Cardiovascular
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Palpitations
- ☐ Weight gain
- ☐ Other_____________________

Skin
- ☐ Itching
- ☐ Mole(s)
- ☐ Rash
- ☐ Other______________________

ENT
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Nosebleed
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Other____________________

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Other____________________

Neurologic
- ☐ Fainting
- ☐ Headache
- ☐ Loss of strength
- ☐ Seizures
- ☐ Tingling/Numbness
- ☐ Tremor
- ☐ Other_______________________

Endocrine
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Weakness
- ☐ Other____________________

Hematology
- ☐ Anemia
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Swollen glands
- ☐ Other______________________

Psychiatric
- ☐ Psychiatric treatment
- ☐ Anxiety
- ☐ Depressed mood
- ☐ Other________________________