Valdosta Health & WELLNESS CLINIC

A NEW BEGINNING, NATURALLY

Patient Information

Legal Name: _____ Referred by: _____
(Last, First, Middle initial)

Address: _____
(Street) (City, State & Zip)

D.O.B: _____ SS#: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Sex: _____ Marital Status: _____ Race: _____

Occupation: _____ Work Number: _____

Emergency Contact

Name: _____ Relationship: _____

Primary phone #: _____ Secondary phone #: _____

Insurance Information

Selfpay: *YES* *NO*

Primary Insurance: _____ Ins Phone Number: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Ins Phone Number: _____

ID Number: _____ Group Number: _____

Account Holder: _____ D.O.B: _____

Relation: _____ Phone Number: _____

Insurance Release

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Practitioner at Valdosta Health & Wellness Clinic. I understand that I am financially responsible for any balance. I also authorize Valdosta Health & Wellness Clinic to bill the insurance company, and to release any information required to process my claim. I have also read the HIPPA privacy notice, and understand that a copy will be provided to me upon my request.

Signature: _____ Date: _____

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Waiver for treatment

I hereby release Valdosta Health & Wellness clinic, Tracey Livingston ANP-BC and all employees from any and all liability associated with or connected to my consultation and treatment. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with Bio-identical Hormone Replacement therapy and any other treatment received as a patient of Valdosta Health & Wellness Clinic. I understand that no provider, nurse, pharmacist, etc. can guarantee that any treatment will provide the desired result. I am participating in treatment by my own choice and assume all risks.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I understand that as a patient of Valdosta Health & Wellness clinic I may be required to have additional testing for continued care.

I understand that Valdosta Health & Wellness provides NON-EMERGENCY care pertaining to Bio-identical hormone replacement, treatment of thyroid disorders and weight loss programs. I agree to see other healthcare providers for treatment that does not pertain to the above listed care. I understand that Valdosta Health & Wellness is not liable for any urgent treatment that I may need now or in the future. I understand that Valdosta Health & Wellness has 24-48 hours to respond to all patient calls, questions, refill requests, etc. I agree that this is an acceptable response time since this is a NON-EMERGENCY clinic.

My signature below indicates that I accept all terms and conditions of Valdosta Health and Wellness Clinic and understand that the requirements for continued care are subject to change at any time.

_____ _____

Signature Date

Bio-Identical Hormone Therapy Assessment

Rate the following symptoms by checking the box that most accurately applies to you.

Symptom	Never	Mild	Moderate	Severe
Weight Gain *(R63.5)*				
Hair Loss *(L65.9)*				
Decreased Libido *(R68.82)*				
Inability to ejaculate *(F52.32)*				
Memory Loss/Brain fog *(R41.840/ R41.9)*				
Increased urinary urge *(R39.15)*				
Decreased urine flow (R39.12)				
Lack of motivation (R45.89)				
Night sweats *(R61.9)*				
Bone Loss (M89.9)				
Loss of muscle mass or tone (M62.89)				
Depressed or unhappy *(F32.9/ R45.2)*				
Mood Changes/ Emotional *(F39/ R45.86)*				
Dry skin or hair *(L85.3)*				
Insomnia *(G47.00)*				
Anxiety *(F41.9)*				
Decreased erections *(F52.21)*				
Fatigue/ no energy *(R53.83)*				
Backache, joint pain, or stiffness				
Irritability *(R45.4)*				

Other symptoms:_____

Have you ever been on any Bio-Identical Hormone Replacement Therapy? If yes what where you prescribed?_____

What goals are you trying to reach with doing BHRT?

_____

Medication List

List any medications, vitamins, and supplements you are currently taking. Please **be as specific as possible even with over the counter medications** as this can effect treatment. Missing information may result in rescheduling your appointment.

You will be asked to provide current information for medications, vitamins and supplements prior to each appointment.

Name	Strength	Tablet, capsule, etc	Amount per day	Diagnosis
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Pharmacy Information

Preferred Pharmacy:_____
Preferred Compounding Pharmacy:_____

- Certain pharmacies that we use for compounding are out of state. If your shipping address is different from your billing address please specify shipping address below so we can inform any out of state pharmacies. It cannot be a P.O box.

Address:_____

Past Medical History

Drug Allergies:

List the name of the medication and side effect below.

1._____,_____

2._____,_____

3._____,_____

4._____,_____

5._____,_____

6._____,_____

7._____,_____

8._____,_____

9._____,_____

10._____,_____

Do you have, or have you ever been treated for any of the following:

☐Diabetes ☐Hypertension ☐Heart Disease ☐Psychiatric Problems

☐Rheumatic Fever ☐Mitral Valve Prolapse ☐UTI ☐Hepatitis/Liver Disease

☐Varicosities/Phlebitis ☐Asthma ☐Lung Disease ☐Hypo/Hyperthyroidism

Other:_____

Do you have any Autoimmune disorders?_____

Do you have any Thyroid problems?_____

Have you ever had any type of Cancer? _____

Who is your Primary Care Provider: _____

Surgical History

List all Surgeries you have had in the past. List the name, date and reason.

1._____,_____,_____

2._____,_____,_____

3._____,_____,_____

4._____,_____,_____

5._____,_____,_____

Hospitalizations

List any time that you were admitted into the hospital overnight (or longer) and the reason.

1._____,_____,_____

2._____,_____,_____

3._____,_____,_____

4._____,_____,_____

5._____,_____,_____

Family History

Breast Cancer	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Colon Cancer	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Ovarian Cancer	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Prostate Cancer	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Osteoporosis	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Diabetes	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Hypertension	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Heart Disease	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____
Kidney Disease	☐ Yes	☐ No	Relation:_____
	☐ Mother's side	☐ Father's side	Living:_____

Do you have any siblings: _____ sisters _____ brothers

Do any of your siblings have health problems? _____

Are you parents still living? _____

Do they have any health problems? _____

Other family history: _____

Social History

Are you married? _____How long? _____

Do you have any children? _____ daughters _____ sons

Are you currently sexually active? _____

Have you ever been treated for an STD? _____

Do you smoke cigarettes?_____ How long?_____

Do you use any smokeless tobacco? _____

Do you use street drugs?_____What kind?_____

Do you drink alcohol?_____

How much alcohol per day,week,month?_____

Do you drink caffeine? _____

How much caffeine per day,week,month?_____

How would you describe your overall general health?_____

What is your current height? _____ current weight? _____

Do you exercise?_____If yes how often?_____

Are you on any type of diet for weight-loss?_____If yes what diet?_____

Are you on any special diet (ex: gluten free)?_____

Have you ever suffered from an eating disorder?_____if yes what type?_____

Have you ever been diagnosed with any vitamin deficiencies?_____ if yes what type?
_____

Have you ever been diagnosed as iron deficient anemic?_____

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Authorization to Release Healthcare Information

_____ _____
Name Date of Birth

I request and authorize Valdosta Health & Wellness Clinic to release healthcare information of the patient listed above to: (ex: family or providers)

NAME	RELATION	ADDRESS	PHONE

This request and authorization applies to:

___ All Medical Records ___ History & Physical ___ Progress Notes

___ Lab Reports ___ Medication Record ___ Imaging Reports

___ Other

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Federal law prohibits the disclosure of the above information without written consent of the patient or authorized representative. I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the medical records director or designee. I understand that 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. I understand that authorizing the disclosure of this health information is voluntary, and I need not sign this form in order to assure treatment.

_____ _____
Signature Date

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Authorization to Request Healthcare Information

_____ _____
Name Date of Birth

I request and authorize the facility listed below to release healthcare information of the patient named above to: Valdosta Health & Wellness Clinic location at 3328 Bemiss Road Valdosta, Ga. 31605. Phone # 229-469-6137. Fax # 229-469-6139.

FACILITY NAME	ADDRESS

This request and authorization applies to:

___ All Medical Records ___ History & Physical ___ Progress Notes

___ Lab Reports ___ Medication Record ___ Imaging Reports

___ Other

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Federal law prohibits the disclosure of the above information without written consent of the patient or authorized representative. I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the medical records director or designee. I understand that 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. I understand that authorizing the disclosure of this health information is voluntary, and I need not sign this form in order to assure treatment.

_____ _____
Signature Date

Billing Policy

- All private pay payments are due when services are rendered.

- We accept payments by cash, money order or credit cards. Checks are accepted for established patients only. There will be a $40 fee for returned checks.

- When checking in for your appointment, you should present your current insurance card to our receptionist at each visit. **Please understand that our relationship is with you, not your insurance company**. If we do not have all the necessary insurance information, we are unable to bill your insurance company and you will be responsible for the total charge at the time of your visit. It is your responsibility to inform us of any changes with your insurance.

- We DO NOT file auto insurance or health insurance related to motor vehicle accidents.

- Minors: It is the policy of Valdosta Health & Wellness clinic that the person or parent accompanying a minor be responsible for payment of co-insurance, co-pays, deductibles, etc. at the time of service. Divorce or custody agreements are between the two parties involved and not Valdosta Health & Wellness Clinic. We will provide a copy of the receipt for reimbursement. Patients aged 18 and older are considered adults and will be responsible for their own accounts.

- **The balance of your account remains your responsibility until the account is paid in full. If your insurance does not pay within 30 days, the balance in full is due by you, as well as any non-covered service by the insurance company, including cost of collection. If your account becomes past due for 30 days or more and no payment arrangement has been made, the total bill will be turned over to collections.**

- A copy of all documents will be given upon request for a fee of $1.00 per page, with a notice of one week ahead of time.

_____ _____

Signature Date

No Show Policy

- If appointments are not rescheduled or canceled atleast the day before the appointment, you will be charged a missed appointment fee of $50.00, which cannot be billed to your insurance company and is due in full before your next appointment.

- If the appointment is a new patient appointment you will be charged $100.00 for a missed appointment, or late cancellation as these appointments take up more time than others.

- Two or more unjustified missed appointments, or 6 months without seeing your practitioner qualifies you to be discharged from this practice. We do not have to inform you of the dismissal decision.

- You must reschedule your appointments, so that you comply with your Practitioner's follow up orders unless approved by your practitioner. Failure to reschedule qualifies you as non-compliant and may result in a dismissal from the practice.

- Failure to settle any acquired no show debts will result in your account being sent to collections.

- The intent of this policy is to prevent delays in care and utilize provider time more efficiently by reducing unused appointments. We appreciate your attention to our policy.

- This policy applies to ALL appointments, **including Telemedicine.**

_____ _____

Signature Date

Non-Covered Services Medical Consent Form

I, _____ understand that some services may not be considered eligible benefits (services and/or supplies may be determined to not be medically necessary such as labs, non-covered or investigational), by my health insurance provider. I understand that my health insurance coverage may have certain restrictions and limitations, such as authorization requirements and non-covered services. Examples of these non-covered services include, but are not limited to, labs, procedures, or medical supplies. I agree to be financially responsible for all related charges if they are not covered by my health insurance plan. I understand that payment is due when services are rendered.

_____ _____

Signature Date

Blood work

- If you are an uninsured patient or have a high deductible, please note that we have self pay prices for labs to help with the cost of treatment.

- It is your responsibility to find out what lab company your insurance will cover. Labs can be drawn in our clinic with a $35 venipuncture fee that we do not bill to your insurance. We can have labs drawn in our office processed and billed by Quest or Labcorp.

- Knowing exactly what your insurance will and will not cover will help eliminate the possibility of unexpected expenses.

- Follow up hormone and thyroid labs will need to be drawn in the morning as soon as possible. Thyroid medication will need to be taken the morning of labs and hormone medication will need to be taken the night before to ensure accurate results.

- Patients that are taking Testosterone injections will need to have labs drawn 4 days after your last injection.

- If the ordered labs are fasting labs, you must refrain from eating and drinking anything other than water, after midnight.

_____ _____

Signature Date

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Prescription Medication Policy

To provide accurate, effective, and compliant prescription medications, our practice has established the following policy regarding prescription refills.

Please remember to have a current list of your medications, supplements, pre-work out, etc. for each appointment to ensure our records are up to date.

Prescription refills

- Patients are typically given enough refills at an appointment to last until their next appointment.
- When needing a refill, contact the pharmacy as they should have the refills on file.
- If the pharmacy does not have a refill on file and you are current with your follow up appointments, we require patients to request refills directly to minimize error. It is the patient's responsibility to request refills in a timely manner. *DO NOT EMAIL, MAIL OR TEXT A REFILL REQUEST.*
- We have 24-48 business hours to respond to refill requests.
- Patients that cancel or no show for scheduled lab appointments, office visits or telemedicine visits will not be given refills until the next appointment.
- If a medication refill is not discussed with the provider during an appointment, the medication will not be refilled. If you realize a medication refill is needed the day after an appointment, you will be required to schedule another appointment to receive a refill.
- Requests for medication changes or new medications will require an appointment with the provider.
- Questions about medications, discussing symptoms of medications will require an appointment. ****If you believe you are having an allergic reaction to a medication, experience chest pain/tightness, etc. go to your nearest emergency room immediately. <u>We are a non-emergency clinic so for immediate/urgent care, go to the E.R.</u> ****
- All medications are to be taken as prescribed. If a patient takes medication in excess of what is prescribed and runs out of the medication early (prior to refill date), the refill will not be authorized early.
- If you have changed pharmacies, call your new pharmacy and request that your prescriptions be transferred from your old pharmacy.
- Medication prescribed by other providers will not be refilled.
- The provider nor the staff of VH&W can give pricing for medications filled through local pharmacies. You will need to contact your pharmacy to discuss prescription costs.

Prior Authorizations

- Some prescribed medications require prior authorization from your insurance company. **The completion of prior authorizations is at the provider's discretion**.
- If the provider approves the completion of a P/A, you will need to contact your pharmacy and request that the pharmacy start a P/A in covermymeds.
- It can take up to 72 business hours for a P/A to be completed after it has been started by the pharmacy.
- Insurance companies can take up to 2 weeks to approve or deny a P/A. You will need to contact your insurance company for their decision.
- Insurance companies often deny authorization for a prescribed medication even though the provider feels it would work best for the patient. **This is beyond our control.**

_____ _____

Name Date Signature Date

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Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

According to HIPAA, we may use and disclose your protected health information without your written authorization for the following reasons:

- Treatment including the provision, coordination, or management of health care and related services by one or more health care providers such as in the case of a referral to a specialist.
- Payment including activities such as filing an insurance claim to obtain reimbursement for services, confirming insurance coverage, obtaining pre-authorizations, and billing and collection procedures.
- Health care operations including administrative, financial, legal and quality improvement activities, such as compliance audits necessary to support and properly conduct treatment and payment activities.

We may contact you by telephone, mail and/or e-mail to provide appointment reminders, test results, treatment information, etc.

Any other uses and disclosures, except as allowed or required by law, will be made only with your written authorization. You may revoke an authorization in writing, but such a revocation will not affect actions already taken by us based upon your prior authorization.

Examples of other uses and disclosures allowed or required by law which do not require a written authorization include but are not limited to:

- To notify family or other individuals involved in your care of emergency or critical situations.
- For public health and safety purposes to prevent or control disease, injury, or disability threats.
- To report suspected victims of abuse, neglect, or domestic violence.
- For health oversight activities such as professional licensure and governmental program evaluation.
- For judicial and administrative proceedings pursuant to a court order or subpoena.
- For law enforcement purposes pursuant to due process.
- For research purposes pursuant to a board approved waiver of authorization and research protection policies.
- For specialized governmental functions such as national security and intelligence activities.
- To comply with Workers' Compensation requirements pursuant to a signed release.

You have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosures. However, we are not required to agree to such a request.
- The right to reasonable requests to receive confidential communications of health information from us by alternative means or at alternative locations.
- The right to inspect and/or receive a copy of your records for a reasonable fee.
- The right to receive an accounting of disclosures of your health information.
- The right to obtain a paper copy of this note from us upon request.

We reserve the right to change the terms of this notice in accordance with the new/revised loss or office procedures and make the new notice effective for all protected health information that we maintain. We will abide by the terms of this notice currently in effect, and you may receive a copy of the current notice at any time upon request.

Name	Date	Signature	Date