Family Health and Wellness Center
Patient Demographics

First Name: ____________________ Last Name: ____________________ Middle Initial: __________

Date of Birth: _____________ Age: __________ Sex: M F Email: _____________________

Race: __________________ Sexual Orientation: ____________________

Address ________________________________ City: ____________________ State: ________ Zip: ___________

Telephone: Home: ______________________ Cell: _____________________ Work: ____________________

Social Security Number: _____________________ Employed: Y N Occupation: _________________

Emergency Contact: _____________________Phone: __________________ Relationship: ___________

Pharmacy Name: ___________________________________ Phone: __________________________

How did you hear about us? **Insurance** **Friend** **Internet** **Other**

INSURANCE INFORMATION

Primary: ________________________ Secondary: _________________________

Phone: __________________________ Phone: _____________________________

ID: __________________ Group#: _____________ ID#: _________________ Group#: _____________

Insured Name: ____________________ DOB: _______________ Insured Social: _______________

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Family Health and Wellness Center (FHWC) for all services rendered. I hereby authorize FHWC to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration, my insurance carrier, or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my healthcare benefits. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.
Signed: _______________________ **Date**: _______________

Patient Communication Authorization

Patient Name: ______________________ Date of Birth: ______________________

I authorize Family Health and Wellness Center to contact me to provide updates, promotions, or other relevant content based on the below preferences:

- ☐ I consent to receive phone calls from Family Health and Wellness Center for appointment reminders, marketing messages, and general two-way communication.
- ☐ I consent to receive SMS text messages from Family Health and Wellness Center for appointment reminders, marketing messages, and general two-way communication. Message frequency varies. Message and data rates may apply.
  Reply HELP for support. Reply STOP to opt out of messages.
- ☐ We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers. By opting in, you confirm you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

  Phone Number: __________________ Okay to leave written or voice messages? Y N

Send my portal invitation to email: _________________________

I authorize Family Health and Wellness Center to release information to

- ☐ Spouse; Name and Contact Information: ______________________________
- ☐ Children; Name and Contact Information: _____________________________
- ☐ Other; Name and Contact Information: ________________________________
- ☐ Do Not Speak to Family Members

Billing Communication:

- ☐ I agree to have my statement emailed or text to me
- ☐ I agree to communicate billing issues via email

Email Address: ____

This authorization can be revoked or modified by notifying us in writing at any time.

Patient Signature: _________________________ **Date:** _______________

Family Health and Wellness Center
Privacy Notice

This notice describes how your medical information may be used and disclosed; this will also discuss how you can obtain 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 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 described 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, its staff and its business associates for purposes of treatment, payment and health care options.

Patient Name: ____________________ Signature: ____________________ Date: ___________

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.
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.

Patient Name: ____________________ Signature: ___________________ Date: ____________

Title or Relationship: ___________________ Witnessed by: __________________________________

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

Signature: __________________________________ Date: ___________________

Financial Policy

All insurance information must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

The 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. 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 $50.00 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. A $50.00 fee will be assessed for all missed appointments and those 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:** ________________

Credit/Debit 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
- There is patient liability (ie. Deductible, Co-Insurance, Copay, et. al)

The office will send a statement notifying the patient 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 ENTIRE 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 No Show/Late Cancellation fees and 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/debit card has been charged for medical treatment/services, and then my insurance carrier subsequently makes payment for those charges, the office will issue a credit to my credit/debit card.

Patient Name: ___________________________________

Type of Cedit/Debit Card: Visa Mastercard Other

Name of Card Holder: ____

16 Digit Number on Card: ____

Expiration Date: _________________ **3 Digit 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 legal fees to the extent allowed by applicable law. I have read, understand, and agree to the financial policy.

Signature of Patient/Responsible Party: _____________________________ **Date:** ______________

Medical History

Name: ________________________________ Date: _____________ Date of Birth: ________________

Drug Allergies and Reaction: ____

____

Past Medical History (Check all that apply)

- ☐ Hypertension
- ☐ Diabetes (Type I or II)
- ☐ Seizures
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Kidney Disorder
- ☐ Bleeding Disorder
- ☐ Autoimmune Disorder
- ☐ Gout
- ☐ COPD
- ☐ Anxiety
- ☐ Depression
- ☐ GERD
- ☐ Other: ______________ _____________________

Past Surgical History (Check all that apply)

- ☐ Appendix
- ☐ Gallbladder
- ☐ Hemorrhoids
- ☐ Stomach or Bowel Surgery
- ☐ Bariatric Surgery
- ☐ Hernia Repair
- ☐ C- Section
- ☐ Prostate
- ☐ Knee Surgery
- ☐ Spine
- ☐ Hip
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Breast
- ☐ Heart Surgery
- ☐ Sinus
- ☐ Biopsy; _____________
- ☐ Cosmetic; ___________
- ☐ Other; ______________ ____________________ ____________________

Screenings (Check all that apply)

- ☐ Laboratory Evaluation: Date ____________________
- ☐ Cardiology Consultation: Date __________________ Location/Provider ____________________
- ☐ Pap Smear: Date _______________________________ Results ______________________________
- ☐ Mammogram: Date ____________________________ Results ______________________________
- ☐ Colonoscopy: Date ____________________________ Results ______________________________
- ☐ Bone Density: Date ____________________________ Results ______________________________

Family History

- Maternal: Alive Deceased; If so, cause __________; Health Issues ________________________
- Paternal: Alive Deceased; If so, cause __________; Health Issues ________________________
- Other Family Members with Health Issues: ____

Social History and Health Habits

Current Relationship Status:

☐ Married ☐ Divorced ☐ Separated
☐ Single ☐ Widowed

Pregnancy History:
Pregnancies: _______ Deliveries: _______ Miscarriage: _________ Abortion: ________ Other: __________

Number of People Living in your Household: ________

Do you use nicotine?

☐ Cigarettes; If so, how many per day _________
☐ Electronic Cigarettes(Vape)
☐ Chew/Pouches

Did you quit? If so when, _________________ Do you want to quit? Y N

Do you use alcohol?
How many alcoholic beverages do you consume per _______ day ______ week ______ month?

Do you use illicit drugs? **Y** **N**

Do you exercise regularly? **Y** **N**

Current Medications

Name	Dosage
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

HIPAA Release Form

Authorization to Release Protected Health Information

Mail or fax completed forms to:

Address: Family Health and Wellness Center 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 (HIPPA), I, the undersigned, grant permission to ____

Fax Number ______________________ to disclose protected health information (as defined in HIPPA) to Family Health and Wellness Center 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 FHWC in writing.

Date:	**Parent/Guardian Name:**	**Date Authorization Effective Until:**
Name (print):	**Signature:**	**Date:**