Family Health and Wellness Center
Patient Demographic Form

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: M F Email: _____

Race: _____ Language: _____ Sexual Orientation: _____

SS#: _____ Employer: _____ Occupation: _____

Spouse's Name: _____ Phone: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy Name: _____ Phone: _____

How were you referred? **Insurance** **Friend** **Internet** **Other**

INSURANCE INFORMATION

Primary: _____ Secondary: _____

Address: _____ Address: _____

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**: _____

Financial Policy

The patient or their guarantor is responsible for payment of sevices that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia, and Lab Fee.** We will submit for the Provider and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen.

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.

Accounts are due upon receipt. For accounts not paid in full in 30 days a 15% service charge per month will be accured to the account. Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee of 35% will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a $35 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 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers 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. Because of high demand for appointments, missed appointments prevent us from scheduling appropriatley 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.

Product Purchases: 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: or
*There is patient liability (ie. 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 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

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 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: _____

Past Medical History

- ☐ Hypertension
- ☐ Diabetes
- ☐ Long Term Steroid Use
- ☐ Seizures
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Cholesterol Disorder
- ☐ Thyroid Disease
- ☐ Kidney Disorder
- ☐ Bleeding Disorder
- ☐ Lupus/ Autoimmune Disorder
- ☐ Gout
- ☐ Other _____

Past Surgical History/Year

- ☐ Gallbladder
- ☐ Hemorrhoids
- ☐ Hysterectomy
- ☐ Heart Surgery
- ☐ Pace Maker
- ☐ Defribulater
- ☐ Prostate
- ☐ Bowel Surgery
- ☐ Tubal Ligation
- ☐ Thyroid Surgery
- ☐ C-Section
- ☐ Bariatric Surgery
- ☐ Cosmetic (Type)
- ☐ Other _____

Family History

- ☐ Heart Disease
- ☐ Breast Cancer
- ☐ GYN Cancer
- ☐ Blood Clots in Lungs or Legs
- ☐ Colon/Bowel Cancer
- ☐ Stroke
- ☐ Prostate Cancer
- ☐ Other _____

Current Medications: Name and Dosage

_____

_____

_____

Social History

- ☐ Tobacco Use: Everyday Some Days Never Former
- ☐ Alcohol Use: Everyday Some Days Never Former
- ☐ Illicit Drugs: Everyday Some Days Never Former _____

Chief Complaint and Review of Systems:

- ☐ Abdominal Pain
- ☐ Anal Itch
- ☐ Anal Pain
- ☐ Anal Warts
- ☐ Anemia
- ☐ Bladder Control Problems
- ☐ Breast Mass/Discharge
- ☐ Constipation
- ☐ Fatigue/Tired
- ☐ Heavy Vaginal Bleeding
- ☐ Hemorrhoids
- ☐ Menopausal Symptoms
- ☐ Painful Periods
- ☐ PMS
- ☐ Rectal Bleeding
- ☐ Rectal Drainage
- ☐ Screening Colonoscopy
- ☐ Unable to hold Bowels
- ☐ Unable to Hold Gas
- ☐ Vaginal Discharge
- ☐ Other: _____

GYN History

How many pregnancies? _____

Are you pregnant? _____

Do you plan to become pregnant? _____

Are you breast feeding? _____

Date of Last:

Menstrual Period: _____

Pap Smear: _____ Result: Normal Abnormal

Colonoscopy: _____ Result: Normal Abnormal

Pelvic Ultrasound: _____ Result: Normal Abnormal

Endometrial Biopsy: _____ Result: Normal Abnormal

Bone Density Scan: _____ Result: Normal Abnormal

Mammogram: _____ Result: Normal Abnormal

Signature: _____ **Date:** _____

Patient Communication Authorization

Patient Name: _____ Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It is okay to call:

☐ Home Phone Number	Leave a message?	Yes	No
☐ Mobile/Cell Phone	Leave a message?	Yes	No
☐ Work Phone Number	Leave a message?	Yes	No

Call Only This Number: _____ Leave a message? Yes No

_____ Do Not Speak to Family Members

I give permission to the individual(s) listed below to receive protected health information:

_____

Send my portal invitation to email: _____

Billing Communication:

- ☐ I agree to have my statement emailed 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:** _____

HIPPA 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:**

HIPPA 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 (FHWC): 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 HIPPA 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:**