PATIENT DEMOGRAPHIC FORM

Last Name: _____ First Name: _____ MI: _____ Age:_____ Sex (M/F): _____

Date of Birth:_____ E-mail:_____ SS#_____

Street address:_____ City/State_____ ZIP:_____

Home Telephone:_____ Cell Telephone:_____ Work Telephone:_____

Chronic Health Conditions:

_____

_____

PATIENT AUTHORIZATION

I, _____, affirm that it is my desire that _____ serve as my primary caregiver in order to assist me in the medical use of marijuana.

Signature:_____ Date:_____

FINANCIAL POLICY

I understand that I am responsible for the charges associated with my medical evaluation, which includes a non-refundable $50.00 scheduling fee as well as the remaining balance. I understand the services will not be billed to insurance and are due at the time of service.

Fees: There may be a $35.00 medical records fee dependent upon access to medical records

I understand that if I cancel or do not show up for a scheduled appointment, my $50.00 is non-refundable. If you need to cancel or reschedule a scheduled appointment, please contact our office at least 24 business hours in advance.

Product purchases: Products are non-refundable or exchangeable

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms

Signature:_____ Date:_____

FAMILY HEALTH & WELLNESS
ROBIN WEST ARNP FNP BC

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: _____