PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? ☐ Patient (Name: _____) ☐ Event (_____)
☐ Practitioner (Name: _____) ☐ Pharmacy (Name: _____)
☐ Social Media (Type: _____) ☐ TV (Station: _____) ☐ Radio (Station: _____)
☐ Web (Keyword Searched: _____) ☐ Signage (_____) ☐ Print (Ad seen in: _____)

In Case of Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

OBGYN Physician's Name: _____ Phone: _____

Address: _____

May we share your clinical information with your PCP/Gyn? ☐ Yes ☐ No

MEDICAL HISTORY

Weight: _____ Last Menstrual Period: _____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____ Age started? _____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____ Age started? _____

Any known drug allergies: ( ) Yes ( ) No If yes please explain: _____

Current Medications and dosage: _____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other _____

Do you have a personal history of? Check all that apply.

Preventative Medical Care:
( ) Medical/GYN Exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:
( ) Breast Cancer.
( ) Uterine Cancer.
( ) Ovarian Cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy Removal of Ovaries.

Birth Control Method:
( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other: _____

Medical Illnesses:
( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer Type: _____ Year: _____

PRINT NAME _____ SIGNATURE _____ DATE _____

HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguard to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI and other documents or information.
2. It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, US mail, text, or any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology, as well as our office promotional material that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide client's access to their records in accordance with state and federal laws
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ **date** _____ **do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

Signature: _____

Waiver of Liability for COVID-19

Rapid IgG/IgM Antibody Blood Screening

I,_____, acknowledge that I have willingly chosen to participate in Maricopa Wellness Center's COVID-19 Rapid Antibody Screening. The test is to detect COVID-19 IgG/IgM antibodies. This test has not been reviewed by the FDA and is used as a screening tool. Negative results do not rule out SARS-CoV-2 infection, particularly in those who have been in contact with the virus. Follow-up testing with molecular diagnostics should be considered to rule out infection and additional testing may be required. Results from antibody screening should not be used as sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status. Positive results may be due to past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, 229E, or others not mentioned.

I understand the screening will be performed by a trained healthcare professional.

I hereby release Maricopa Wellness Center and its officials, employees, and agents from liability for injury or death which may occur as a result of my participation in the COVID-19 Rapid Blood Screening. I sign this waiver and release willingly and of my own volition without coercion of any kind. I understand that by signing this form I give up all rights whatsoever to recover damages from injury or death arising out of the COVID-19 Antibody Rapid Screening. I understand that regardless of results I should still practice social distancing and other recommendation set by healthcare professionals and the CDC.

_____

Print

_____ _____

Signature Date

Financial Responsibility

Maricopa Wellness Center does not accept health insurance. There is a fee of $100 for today's office visit. Office visit fee does not guarantee COVID-19 lab testing. This fee is non-refundable and must be paid in full prior to your visit. You may personally submit the $100 office visit fee to your health insurance for reimbursement. We do not guarantee reimbursement and cannot submit this for you. There is no charge through Maricopa Wellness Center for COVID-19 lab testing or Rapid Antibody Screening. COVID-19 testing may need to be sent to a private lab. Maricopa Wellness Center will forward your health insurance information to the lab. The lab is responsible for billing.

There is also a $50 fee for appointments canceled without a 24 hour notice or for no show appointments that must be paid before your next scheduled appointment.

Thank you for choosing Maricopa Wellness Center.

_____

Print Name

_____ _____

Signature Date

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read and sign the following informed consent:

1. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. I understand the testing unit is not acting as my medical provider, this does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

Signature of patient/guardian _____ Date _____

AGREEMENT FOR SELF-ISOLATION

The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement in order to protect the public's health. Thank you for agreeing to cooperate.

Please agree to each of the following statements by initialing and signing below.

____ I understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.
____ I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.
____ I agree that if my COVID-19 test results are positive, I will remain isolated for 7 days from this day of testing OR until at least 72 hours after my symptoms have resolved, whichever is longer.
____ I agree that if my COVID-19 test results are negative, I will remain isolated until at least 72 hours after my symptoms have resolved.
____ I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.
____ I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID-19 infection.

Signature of patient/guardian _____ Date _____

Relationship to patient _____

Maricopa Wellness Center
Med Spa and Rejuvenating Medicine

COVID-19 Antigen Testing

I voluntarily consent and authorize Maricopa Wellness Center to conduct collection, testing, and analysis for the purposes of a COVID-19 antigen test. I acknowledge and understand that my COVID-19 antigen test will require the collection of an appropriate sample through a nasopharyngeal swab or anterior nasal swab. I understand that there are risks and benefits associated with undergoing an antigen test for COVID-19 and there may be a potential for false positive or false negative test results. Any results I receive are for informational purposes only and do not constitute a medical diagnosis. I assume complete and full responsibility to seek and obtain medical and other advice relating to this testing and any results I receive. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

I consent to receiving email, text messages, and phone calls at the email address and phone number provided by me. My results may be reported to me through any of the foregoing means or any other reasonable mechanism, including text messages or web-based applications. I understand that my results and the information provided by me may be reported to the ordering physician, my employer, any of my or their designees, and public health authorities as required by law. My results and the information provided by me may also be used by Maricopa Wellness Center for internal and industry research purposes.

I expressly waive, release and forever discharge for myself, my heirs, estate, executors, administrators, successors and assignees, Maricopa Wellness Center and its employees, owners and representatives, as well as my employer or any other company involved with this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees (collectively, "Releasees") from any and all claims, demands, actions and causes of action, now known or hereafter known in any jurisdiction throughout the world, on account of injury, death or property damage arising out of or attributable to my participation in this testing, whether arising out of the negligence of Maricopa Wellness Center or any Releasee or otherwise. I further agree to indemnify, defend and hold harmless the Releasees from any litigation expense, attorney fees, or claim for personal injury in connection with my participation in this testing.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form along with the Maricopa Wellness Center Privacy Practices Notice. I understand Maricopa Wellness Center does not accept insurance and there is an additional fee associated with the antigen testing that I am responsible for at time of testing. I have been informed about the purpose of the COVID-19 antigen test, procedures to be performed, potential risks and potential benefits. I have been provided an opportunity to ask questions before proceeding with a COVID-19 antigen test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 antigen test, I may decline to receive continued services.

_____ _____ _____

Printed Name Signature Date

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date

_____

Phone Number