Wellstone HEALTH PARTNERS

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Ethnicity: ❑ Declined ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Race (optional): ❑ Declined ❑ American Indian / Alaska Native ❑ Asian ❑ White ❑ Other ❑ Black or African American ❑ Native Hawaiian/Pacific Islander ❑ Unknown	Social Security #	Birth date: / /	Age:	Sex: ❑ M ❑ F

Primary Language Spoken: _____	Secondary Language: _____

Street Address:	Home Phone # ( )	Cell # ( )

City:	State:	Zip Code:	Email address:

Occupation:	Employer:	Work Phone # ( )

Referred to clinic by: (please check one box)	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

Preferred Pharmacy (Please include name & address)

❑ Local Pharmacy: _____

❑ Mail Order: _____

INSURANCE INFORMATION

Primary Insurance Carrier:	*Who is the insured?*	*Relationship to the Insured:*
Member ID #	*Group Number:*	*Birth Date:*
Secondary Insurance Carrier:	*Who is the insured?*	*Relationship to the Insured:*
Member ID #	*Group Number:*	*Birth Date:*

GUARANTOR / RESPONSIBLE PARTY

Name and address:	DOB: SS#:	Home Phone: Work Phone:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home Phone: Work Phone:

This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ***Wellstone Health Partners*** *or my insurance company to release any information required to process my claims*

Patient/Guardian Signature Date:

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Address: _____

Date of Birth:_____ Social Security Number: _____

Authorizes ***Wellstone Health Partners***, to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip_____ Phone Number: _____

□ Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? □ Yes □ No

May we contact you at home and/or leave a message regarding appointments? □ Yes □ No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid. □ Yes □ No

_____ _____

Signature of Patient or Representative Relationship to Patient

_____ _____

Date Signed Witness Signature

Office Policies

Patient Name: _____ Date of birth: _____

As a patient of Wellstone Health Partners I understand that the following policies are currently in effect:

- A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.
- A $25.00 may be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. I also understand this fee, if assessed, must be paid prior to my next visit with Wellstone Health Partners.
- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.
- **I am to present proof of my insurance coverage at *every* office visit**.
- **I understand if I am more than 15 minutes late for my scheduled appointment I *may* be asked to reschedule for another day.**
- **Finally, I understand that I am to allow at least 48 hours for my prescription refills**.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

_____ _____

Patient Signature **Date**

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Wellstone Health Partners to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Wellstone Health Partners

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Wellstone Health Partners reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Wellstone Health Partners is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

_____

Relationship to Patient

PERMISSION TO RELEASE MEDICAL RECORDS	
Name:	
Date of Birth:	Social Security #:
FROM:	**TO: Wellstone Health Partners**
	Dr. _____
	Address_____
	City/State_____
	Phone #_____
	Fax #_____

Release records for the following dates of service: _____

The following information is requested and may be released:		
□ **All Records**	□ Operative Reports	□ Medication Information
□ Medical Summary	□ EKG Reports	□ X-Ray Reports
□ Progress Notes	□ Lab Reports	□ Other

I □ *do* □ *do not* consent to transmission of my medical records via fax machine.

I recognize the information disclosed may contain mental health information that is protected by state and federal laws**.**
I □ *do* □ *do not* consent to the disclosure of this information.

Signature:_____Date:_____

I recognize the information disclosed may contain drug/alcohol information that is protected by state and federal laws**.**
I □ *do* □ *do not* consent to the disclosure of this information.

Signature:_____Date:_____

I recognize the information disclosed may contain information regarding sexually transmitted diseases or HIV/Aids testing**.**
I □ *do* □ *do not* consent to the disclosure of this information.

Signature:_____Date:_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION	
Signature of Patient or Representative:	
Relationship to Patient:	Date:

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for **Wellstone Health Partner**s to access my pharmacy benefits data electronically through RxHub. This consent will enable **Wellstone Health Partners**:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medication prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

Wellstone HEALTH PARTNERS

Name:_____

DOB:_____

PrimePATIENT Portal Registration

PrimePATIENT is a secure online portal that allows you to easily access your patient records from the comfort of your own home, including:

- Viewing upcoming appointments
- Receiving diagnostic lab results and visit summaries
- Requesting prescription renewals
- Updating personal information
- Securely messaging the clinic
- Pre-registering for visits
- Receiving electronic appointment reminders

Please check one option below to indicate your preference for patient record access through PrimePATIENT.

☐ **Yes, I would like to receive an invitation for PrimePATIENT.**

Please PRINT your email clearly below:

☐ **I am already registered for PrimePATIENT through Wellstone.**

☐ **No, I do not want to register for PrimePATIENT access at this time.**

Wellstone HEALTH PARTNERS

PLACE PATIENT STICKER HERE

WELLSTONE FAMILY MEDICINE
800 West Central Texas Expressway, Suite 125
Harker Heights, TX 76548
(p) 254.618.1050 (f) 254.618.1058

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

What problem can we help with today? _____

PAST MEDICAL HISTORY			
❑ NO MEDICAL PROBLEMS			
Problem	**Type/Comment**	**Problem**	**Type/Comment**
❑ Acid Reflux/GERD		❑ Heart Disease	
❑ Anemia		❑ Hepatitis C	
❑ Anxiety		❑ HIV	
❑ Asthma		❑ High Cholesterol	
❑ Bleeding Disorder		❑ High Blood Pressure	
❑ Cancer		❑ Kidney Disease	
❑ COPD		❑ Liver Disease	
❑ Depression		❑ Migraines	
❑ Diabetes		❑ Sleep Apnea	
❑ Hayfever (Allergies)		❑ Thyroid Disease	
❑ Other _____			

PAST SURGICAL HISTORY		
❑ NO PREVIOUS SURGERIES		
Year	**Type**	**Hospital/Doctor**

HOSPITALIZATIONS		
❑ NO PREVIOUS HOSPITALIZATIONS		
Year	**Type**	**Hospital/Doctor**

FAMILY HISTORY

	Mother	Father	Sibling	Other		Mother	Father	Sibling	Other
❑ Allergies	❑	❑	❑	❑	❑ High Blood Pressure	❑	❑	❑	❑
❑ Asthma	❑	❑	❑	❑	❑ Migraines	❑	❑	❑	❑
❑ Bleeding Disorder	❑	❑	❑	❑	❑ Seizures	❑	❑	❑	❑
❑ Cancer: _____	❑	❑	❑	❑	❑ Stroke	❑	❑	❑	❑
❑ Depression/Anxiety	❑	❑	❑	❑	❑ Thyroid Problems	❑	❑	❑	❑
❑ Diabetes	❑	❑	❑	❑	❑ Other:	❑	❑	❑	❑
❑ Heart Disease	❑	❑	❑	❑					

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS

Medication Name	Strength	Frequency Taken

MEDICATION AND FOOD ALLERGIES

❑ **No Medication Allergies** ❑ Latex Allergy ❑ Iodine (Shellfish) Allergy

Medication/Food	Type of Reaction		Medication/Food	Type of Reaction

SOCIAL HISTORY

Occupation	What do/did you do for work? Are you retired? ❑ Yes ❑ No
Alcohol	Do you drink alcohol? ❑ Yes ❑ No If yes, what kind(s)?
	How many per week? Has anyone been concerned about your drinking? ❑ Yes ❑ No
Tobacco	Do/did you use tobacco? ❑ Yes ❑ No Secondhand smoke exposure? ❑ Yes ❑ No
	Cigarettes – packs/day: Number of years: Year quit:
Other	Do you currently use recreational or street drugs? ❑ Yes ❑ No

CURRENT SYMPTOMS (PLEASE CIRCLE) OR ❑ NO SYMPTOMS			
Constitutional/General	Nipple Discharge	Indigestion	**Endocrine**
Fatigue	**Cardiovascular**	**Genitourinary**	Heat Intolerance
Fever	Chest Pain	Burning with Urination	Cold Intolerance
Chills	Fainting	Blood in Urine	Excessive Thirst
Weight Loss	Palpitations	Loss of Urine	Excessive Hair Growth
Weight Gain	Waking up Short of Breath	Urinating Frequently	**Psychological**
Loss of Appetite	**Respiratory**	Painful Urination	Anxiety
Eyes	Cough	**Skin**	Depression
Double Vision	Shortness of Breath at Rest	Rash	Homicidal Ideation
Eye Pain	Shortness of Breath-Exercise	Itching	Suicidal Ideation
Blurred Vision	Sputum	New Skin Lesions	**Hematological/Lymphatic**
Change in Vision	Wheezing	**Neurological**	Easy Bleeding
Ear, Nose, Mouth, Throat	**Gastrointestinal**	Seizures	Easy Bruising
Stuffy Nose	Nausea	Frequent Falls	Lymph Node Enlargement
Runny Nose	Vomiting	Dizziness	Ice Chewing
Ringing in Ear	Diarrhea	Headaches	**Allergic/Immunological**
Trouble Swallowing	Constipation	**Musculoskeletal**	Allergic Dermatitis
Sore Throat	Heartburn	Joint Pain	Frequent Illnesses
Ear Pain	Blood in Stools	Joint Swelling	Sinus Allergy Symptoms
Breasts	Black Stools	Muscular Weakness	
Lumps	Abdominal Pain	Back Pain	

Office Use Only

Reviewed by MD: _____ Date: _____