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

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Patient Name: ____ Date: _________________

Parent Name(s): ____

What problem can we help with today? ____

Who is your child's doctor? ____ ❑ **No Primary Doctor**

BIRTH HISTORY		
Any mother's health problems during pregnancy?	❑ Yes	❑ No
Any complications with the delivery?	❑ Yes	❑ No
Was your child born full term?	❑ Yes	❑ No
What was the method of delivery?	❑ Vaginal	❑ C-section
Did they spend any time in a NICU?	❑ Yes	❑ No
Birth Weight: _____________________________		

PAST MEDICAL HISTORY			
❑ **NO MEDICAL PROBLEMS** ❑ Other _______________________________________			
Are all of your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure			
Problem	**Type/Comment**	**Problem**	**Type/Comment**
❑ Acid Reflux/GERD		❑ Diabetes	
❑ Anemia		❑ Hayfever (Allergies)	
❑ Asthma		❑ Head Injury	
❑ Bleeding Disorder		❑ Migraines	
❑ Cancer		❑ Sleep Apnea	

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

*Additional sheet for listing surgeries available at the front desk

FAMILY HISTORY		
❑ Allergies	❑ Diabetes	❑ Seizures
❑ Asthma	❑ Heart Disease	❑ Stroke
❑ Bleeding Disorder	❑ High Cholesterol	❑ Other:
❑ Cancer: ___________________	❑ Migraines	

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS		
Medication Name	Strength	Frequency Taken

*Additional sheet for listing medications and/or allergies available at the front desk

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 grade is your child in? ___________	Do they listen to loud music? ❑ Yes ❑ No
Other	Is your child exposed to tobacco smoke (secondhand)? ❑ Yes ❑ No	
Pets	Are there pets in the home? ❑ Yes ❑ No If so, what types?❑ Dogs ❑ Cats ❑ Birds ❑ Reptiles (lizards, turtles, etc) ❑ Other: ___________	

CURRENT SYMPTOMS (PLEASE CIRCLE) OR ❑ NO SYMPTOMS			
Constitutional/General	**Respiratory**	Indigestion	**Endocrine**
Fever	Cough	**Genitourinary**	Excessive Thirst
Weight Loss	Shortness of Breath at Rest	Blood in Urine	**Psychological**
Loss of Appetite	Shortness of Breath-Exercise	Urinating Frequently	Anxiety
Ear, Nose, Mouth, Throat	Sputum	**Skin**	Depression
Stuffy Nose	Wheezing	Rash	**Hematological/Lymphatic**
Runny Nose	**Gastrointestinal**	Itching	Easy Bleeding
Sore Throat	Vomiting	**Neurological**	Easy Bruising
Ear Pain	Diarrhea	Seizures	Lymph Node Enlargement
Cardiovascular	Constipation	Headaches	Ice Chewing
Chest Pain	Blood in Stools	**Musculoskeletal**	**Allergic/Immunological**
Fainting	Black Stools	Joint Pain	Allergic Dermatitis
	Abdominal Pain	Joint Swelling	Frequent Illnesses

Office Use Only

Reviewed by MD: ____ Date: ________________________