414 Dabney Drive
Henderson, NC 27536

Henderson Wellness Center, PA

Phone: (252)430-8000
Fax: (252)430-8200

(Please Print)

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
Mailing address:	City:	State and zip code:				
Social Security no:	Email address (optional):	Home phone:	Cell phone:			
Occupation:	Employer:	Employer phone no.: ( )				
Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Internet			
☐ Family	☐ Friend	☐ Close to home/work	☐ Flyer	☐ Other		
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )			
Is this person a patient here? ☐ Yes ☐ No						
Occupation:	Employer:	Employer address:	Employer phone no.: ( )			
PRIMARY INSURANCE:						
Subscriber's name (if different):	Subscriber's S.S. no.:	Birth date:	ID#:	Group#:	Co-payment: $	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		
SECONDARY INSURANCE (if applicable):	Subscriber's name and birth date:	ID#:	Group#:			
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )			

APPOINTMENT CANCELLATION AND BILLING POLICY

We realize that emergencies occur, however in order to help us be available to patients who would like to be seen we request that you notify us if you need to cancel or reschedule an appointment. As a courtesy to our patients, we will bill your insurance for you. Keep in mind though that even though your insurance will be billed you are ultimately responsible for your bill.

The above information is true to the best of my knowledge. I authorize Henderson Wellness Center, PA to treat me. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Henderson Wellness Center, PA to release any information required to process my claims.

Patient/Guardian signature *Date*

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In an effort to provide the best medical services, we have established the following policies.
Your signature below signifies your willingness and understanding to comply with our policies.

POLICY STATEMENT: PAYMENT POLICY _____ Initial

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Henderson Wellness Center, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf if your insurance card is **presented at the time of service.**
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to pay in full at the time of your office visit.
- If your deductible hasn't been met for the year, we require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed. All co-payments are also due at the time of service.
- We accept cash, check, and credit or debit card payments. There is a $40.00 returned check fee in addition to fees charged by your financial institution.
- If your insurance carrier has not paid a claim submitted by Henderson Wellness Center within sixty (60) day of submission, you agree to take an active part in the recovery of your claim. You are then responsible for contacting your insurance company to try to recover your claim. If your insurance carrier has not paid a claim submitted by Henderson Wellness Center within ninety (90) days of submission, you will be **responsible for payment in full** of any outstanding balance. If your personal balance exceeds $100 at any given time, your care may be terminated. If a collection agency is used to collect any past due balances, you will be responsible expenses incurred in collecting that debt including but not limited to attorney fees and court costs.

POLICY STATEMENT: PRESCRIPTION REFILL POLICY _____ Initial

- Please allow 1-2 business days for all prescription refills. Ask your pharmacy to fax a refill request to the office at 252-430-8200 to speed up the process. If you use a mail order pharmacy, please allow 2 to 3weeks. Please note that antibiotics and pain medication will not be refilled. You must call the office to schedule a follow up appointment for these medications.

POLICY STATEMENT: CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION ___Initial

- It is your responsibility to advise the clinic of any change in insurance coverage, or changes in name, address, or telephone number

POLICY STATEMENT: FORMS/PAPERWORK _____ Initial

- Please allow 2-4 business days for any forms/paperwork to be completed.

POLICY STATEMENT: ATTENDING TO CHILDREN _____ Initial

- We know that it can be difficult to find childcare. However, the clinic is full of dangerous items.
- Please monitor your children at all times while at the clinic. We will not monitor your children during your office visit.
- We love kids,however children should not be present during procedures. It's unsafe.

POLICY STATEMENT: CANCELLATION/ NO SHOW _____ Initial

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee; this will not be covered by your insurance company.**

- We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled appointment time we will have to reschedule the appointment.**

Signature: _____ Date:_____

If Parent or Guardian, Name of Child:_____

Review of Systems

Do you now or have you had any of the problems related to the following systems?

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other:_____

Eyes

Blurred Vision	Y	N
Doubled Vision	Y	N
Pain	Y	N

Other:_____

Allergic / Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other:_____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numb/tingling	Y	N

Other:_____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other:_____

Gastrointestional

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Heartburn	Y	N

Other:_____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Last Eye & Dental Exam

Date – Last eye exam:_____

Date – Last dental exam:_____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistant Itch	Y	N

Other:_____

Musculoskeletal

Joint pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other:_____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other:_____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary Frequency	Y	N

Other:_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other:_____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other:_____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Sexual History

Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N

Other (i.e. sexual trauma):_____

List Any Other Medical Problems You May Have

_____

_____

_____

List All Previous Operations With Dates

_____

_____

_____

_____

_____

List All Current Medications and Dosages

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever been told to take antibiotics prior to dental surgery or surgical procedures? **Y** **N**

Mark if you are allergic to:

____ Penicillin ____ Sulfa ____ Codeine

____ Morphine ____ Iodine ____ Adhesive Tape

List Any Other Medical Allergies: _____

_____

____ **No Known Medical Allergies**

Family History(List Significant Illnesses and If they are living or deceased)

Grandparents:_____

Father:_____

Mother: _____

Brothers:_____

Sisters:_____

Children:_____

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound to our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, billing records, but not including psychotherapy notes.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

8. I authorize you to release any medical information about me to the people below. This release is valid until I revoke it in writing (enter N/A if you do not wish this information released to any 3rd party except under the circumstances covered by present HIPPA law).

   a. Relationship:

   b. Relationship:

   c. Relationship:

   d. Relationship:

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 252-430-8000.

I have personally approved the release of my medical information to those people named above in section 8.

Signature_____

Date _____

Name of Patient _____