# Henderson Wellness Center
# Medical Patient

Please help us keep accurate records by filling out this form completely.
This will assist us in making referrals and sending prescriptions

Name Mr. Mrs. Miss Ms. (circle one) _____

Date of Birth_____ Address _____

City _____ State ____ Zip _____

Home Phone _____Cell Phone _____

Married ___ Single ___ Divorced ___ Widowed ___

Email address _____

Occupation _____ Employer _____

Phone _____

Emergency Contact Name _____ Number _____

Have there been any changes to your insurance since your last visit? Yes No
If so, what changes have been made? _____

**HIPPA Release:**

I authorize you to release the following information to the people listed below. This release is valid until I revoke it in writing.

a. Relationship

b. Relationship

c. Relationship

d. Relationship

A full disclosure of your HIPPA rights are available upon patient request.

Signature: _____ Date: _____

Print name of Patient: _____

Patient Name: _____ DOB: _____ Date: _____

| Chief Complaint: |
|---|
| |

**Review of Symptoms: Please circle Y or N if you are experiencing any of these symptoms TODAY.**

| **Constitutional** | **Constitutional** | **Genitourinary** | **Genitourinary** |
|---|---|---|---|
| Temperature | Y or N | Frequency | Y or N |
| Chills | Y or N | Urgency | Y or N |
| Muscle Aches | Y or N | Hesitancy | Y or N |
| Poor Appetite | Y or N | Night Time Frequency | Y or N |
| Poor Sleep | Y or N | Urinary Incontinence | Y or N |
| Night Sweats | Y or N | Blood In Urine | Y or N |
| Weight Gain | Y or N | **Female** | **Female** |
| Weight Loss | Y or N | Pregnant | Y or N |
| **Eyes** | **Eyes** | Irregular Menses | Y or N |
| Discharge | Y or N | Missed Menses | Y or N |
| Redness | Y or N | Abnormal Bleeding | Y or N |
| Itchiness | Y or N | Painful Sex | Y or N |
| Vision Changes | Y or N | Vaginal Discharge | Y or N |
| **Ears** | **Ears** | Burning w/ Urination | Y or N |
| Pain | Y or N | **Male** | **Male** |
| Discharge | Y or N | Penile Discharge | Y or N |
| Pressure | Y or N | Erectile Dysfunction | Y or N |
| Difficulty Hearing | Y or N | **Musculoskeletal** | **Musculoskeletal** |
| **Nose** | **Nose** | Joint Pain | Y or N |
| Nose Bleeds | Y or N | Swelling | Y or N |
| Discharge | Y or N | Stiffness | Y or N |
| Post Nasal Drip | Y or N | Muscle Pain | Y or N |
| Congestion | Y or N | **Neurological** | **Neurological** |
| Sinus Pressure | Y or N | Headache | Y or N |
| **Throat** | **Throat** | Dizziness | Y or N |
| Soreness | Y or N | Weakness | Y or N |
| Redness | Y or N | Difficulty Walking | Y or N |
| Difficulty Speaking/Swallowing | Y or N | Numbness | Y or N |
| Exudate/Pus | Y or N | Tingling | Y or N |
| **Gastrointestinal** | **Gastrointestinal** | **Psychiatric** | **Psychiatric** |
| Abdominal Pain | Y or N | Depressed | Y or N |
| Heartburn | Y or N | Anxiety | Y or N |
| Nausea | Y or N | Suicidal Ideation | Y or N |
| Vomiting | Y or N | **Hematological/Lymph** | **Hematological/Lymph** |
| Diarrhea | Y or N | Bruising | Y or N |
| Constipation | Y or N | Fatigue | Y or N |
| Change in Bowel Habits | Y or N | Anemia | Y or N |
| Bloody Stool | Y or N | Recent Corticosteroid Treatment | Y or N |
| Black Stool | Y or N | Heat Intolerance | Y or N |
| Hemorrhoids | Y or N | Cold Intolerance | Y or N |
| **Cardiovascular/Respiratory** | **Cardiovascular/Respiratory** | **Skin** | **Skin** |
| Shortness of Breath | Y or N | Rash | Y or N |
| Wheezing | Y or N | Lesions | Y or N |
| Lower Extremity Swelling | Y or N | Hair Loss | Y or N |
| Chest Pain | Y or N | | |
| Palpitations | Y or N | | |
| Cough | Y or N | | |
| Phlegm | Y or N | | |

# Patient History

**Please List Any Other Medical Problems You May Have**

**List All Previous Operations with Dates**

**List All Current Medications and Dosages**

**List Any Medical Allergies (medications, etc.)**

**Family History (List Significant Illnesses and If They Are Living or Deceased)**

**Grandparents:** _____

**Father:** _____

**Mother:** _____

**Brothers:** _____

**Sisters:** _____

**Other:** _____

**Social History:**

**Smoke: Y or N**

**How much/often:** _____

**Drink: Y or N**

**How much/often:** _____

**Other:** _____

**Anything else we should know about?**

**414 Dabney Drive**
**Henderson, NC 27536**

**Henderson Wellness Center, PA**

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

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:_____