

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.

<p>Constitutional</p> <p>Temperature Chills Muscle Aches Poor Appetite Poor Sleep Night Sweats Weight Gain Weight Loss</p> <p>Eyes</p> <p>Discharge Redness Itchiness Vision Changes</p> <p>Ears</p> <p>Pain Discharge Pressure Difficulty Hearing</p> <p>Nose</p> <p>Nose Bleeds Discharge Post Nasal Drip Congestion Sinus Pressure</p> <p>Throat</p> <p>Soreness Redness Difficulty Speaking/Swallowing Exudate/Pus</p> <p>Gastrointestinal</p> <p>Abdominal Pain Heartburn Nausea Vomiting Diarrhea Constipation Change in Bowel Habits Bloody Stool Black Stool Hemorrhoids</p> <p>Cardiovascular/Respiratory</p> <p>Shortness of Breath Wheezing Lower Extremity Swelling Chest Pain Palpitations Cough Phlegm</p>	<p>Constitutional</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N Y or N Y or N</p> <p>Eyes</p> <p>Y or N Y or N Y or N Y or N</p> <p>Ears</p> <p>Y or N Y or N Y or N Y or N</p> <p>Nose</p> <p>Y or N Y or N Y or N Y or N Y or N</p> <p>Throat</p> <p>Y or N Y or N Y or N Y or N</p> <p>Gastrointestinal</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N Y or N Y or N Y or N Y or N</p> <p>Cardiovascular/Respiratory</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N Y or N</p>	<p>Genitourinary</p> <p>Frequency Urgency Hesitancy Night Time Frequency Urinary Incontinence Blood In Urine</p> <p>Female</p> <p>Pregnant Irregular Menses Missed Menses Abnormal Bleeding Painful Sex Vaginal Discharge Burning w/ Urination</p> <p>Male</p> <p>Penile Discharge Erectile Dysfunction</p> <p>Musculoskeletal</p> <p>Joint Pain Swelling Stiffness Muscle Pain</p> <p>Neurological</p> <p>Headache Dizziness Weakness Difficulty Walking Numbness Tingling</p> <p>Psychiatric</p> <p>Depressed Anxiety Suicidal Ideation</p> <p>Hematological/Lymph</p> <p>Bruising Fatigue Anemia Recent Corticosteroid Treatment</p> <p>Skin</p> <p>Rash Lesions Hair Loss</p>	<p>Genitourinary</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N</p> <p>Female</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N</p> <p>Male</p> <p>Y or N Y or N</p> <p>Musculoskeletal</p> <p>Y or N Y or N Y or N Y or N</p> <p>Neurological</p> <p>Y or N Y or N Y or N Y or N Y or N Y or N</p> <p>Psychiatric</p> <p>Y or N Y or N Y or N</p> <p>Hematological/Lymph</p> <p>Y or N Y or N Y or N Y or N</p> <p>Skin</p> <p>Y or N Y or N Y or N</p>
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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 DR
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 your 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 are 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, credit, & debit card payments. There is a \$25 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) days 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 \$100.00 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 for expenses incurred in collecting that debt including but not limited to attorney fees and court cost.

Policy Statement: Prescription Refill Policy _____ (Initial)

- Please allow 24 – 48 business hours for all prescription refills. Ask your pharmacy to fax a refill request to the office so that we may serve you faster. If you use a mail order pharmacy, please allow 2 – 3 weeks for refills.
- Antibiotics, pain medications, & other controlled substances **will not be refilled** without an office visit. You must call the office to schedule these visits. **They are not walk in needs.**

Policy Statement: Changes in Demographics and Insurance Information _____ (Initial)

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

Policy Statement: Forms/Paperwork _____ (Initial)

- Please allow 24 – 48 business hours for any forms/paperwork to be completed. (A fee of \$25 may apply for excessive paperwork)

Policy Statement: Attending Children _____ (Initial)

- We know that it can be difficult to find childcare. However, the office is full of dangerous items. Please monitor your children at all times. We will not monitor your children for you during your visit.
- We love kids, however, they should never be present for procedures as it is 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/reschedule an appointment, you may be preventing another

patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel/reschedule and we are unable to schedule you for a visit, due to a seemingly "full" schedule. **If an appointment is not cancelled or rescheduled at least 24 hours in advance you will be charged a \$25 missed appointment fee; this will not be covered by your insurance company.**

- We understand delays can happen however we must try to keep our other patients and the provider on time. **If you are more than 15 minutes late for your appointment you will be asked to reschedule and a \$25 missed appointment fee will be charged.**
- **If you incur 2 consecutive missed appointment fees resulting in a balance of \$50.00 you will be required to pay this balance in full before scheduling another appointment.**
- **Due to an excessive amount of missed appointments without 24 hours' notice you are only allowed 3 total missed appointments (without the required 24 hours' notice). Once you reach your third missed appointment you will be discharged from the practice. This applies to the lifetime of your care with Henderson Wellness Center**

Signature: _____ Date: _____

If Parent or Guardian, Name of Child/Patient: _____