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Health and Wellness

Patient Information

Last Name: _____ First Name:_____ MI: _____

DOB:_____ Age:_____ Social Security Number:_____

Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Gender: _____ Marital Status:_____ Race: _____

Ethnicity (Hispanic/Non-Hispanic/Latino/Non-Latino: _____

Language: _____Email:_____

Employer Name:_____ Work Number:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Name (1):_____Relation:_____

Home Phone: _____ Cell Phone:_____

Okay to Release Medical Information? ☐ Yes ☐ No

Emergency Contact Name (2):_____ Relation:_____

Home Phone: _____ Cell Phone:_____

Okay to Release Medical Information? ☐ Yes ☐ No

Do you have a living will?_____ Do you have a DNR (Do Not Resuscitate order)?_____

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Primary Insurance Name: _____ Subscriber Number: _____

Address:_____ City:_____

State:_____ Zip Code:_____ Group Number: _____

Guarantor: _____ Guarantor Social Security #:_____

Guarantor DOB: _____

Secondary Insurance Name: _____ Subscriber Number:_____

Address:_____ City:_____

State: _____ Zip:_____ Group Number: _____

Guarantor: _____ Guarantor Social Security #:_____

Guarantor DOB: _____

Medical History					
CONDITION	**YOU**	**RELATIVE**	**CONDITION**	**YOU**	**RELATIVE**
Diabetes			Migraines		
High Blood Pressure			Seizures		
Heart Attack			Kidney Disease		
Congestive Heart Failure			Gallstones		
Asthma			GERD/Acid Reflux		
COPD			Constipation		
Tuberculosis			Mental Illness (Please list)		
Thyroid Disease			Arthritis		

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Anemia			Glaucoma/Macular Degeneration		
Leukemia			Cancer (Please Specify)		
Sickle Cell			Bleeding Disorders		

Other Current or Past Medical Conditions Not Listed Above (Please Specify):

_____
_____
_____

CURRENT MEDICATIONS					
MEDICATION	**STRENGTH**	**DIRECTIONS**	**MEDICATION**	**STRENGTH**	**DIRECTIONS**

LOCAL PHARMACY: _____ Phone Number: _____

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MAIL ORDER PHARMACY:_____ **Phone Number:**_____

ALLERGIES

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY		
TYPE/LOCATION	**DOCTOR**	**DATE**

HOSPITALIZATION	
HOSPITAL/YEAR	**REASON**

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SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No If so, what kind? _____

How much do you use daily? _____ How Long? (Years/Months)_____

Interested in quitting? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No If so, how often? ☐ Daily ☐ Socially ☐ Seldom

What kind of alcohol? _____

Mother (Alive/Deceased)?:_____ Father (Alive/Deceased):_____

If either deceased, what was the cause of death: _____

How many siblings?_____ Brothers_____ Sisters_____

Do you have children? _____ How many (Daughters/Sons)?_____

Do you see a specialist? _____ Doctor's Name/Specialty:_____

_____

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OBGYN HISTORY (WRITE N/A IF DOES NOT APPLY): _____

Who is your current OBGYN?_____ Phone #:_____

Age of First Menstrual Cycle?_____ Last Menstrual Cycle Start Date:_____

Average Length of Cycle:_____ Do you use birth control?_____

Birth control method?_____Do you experience any pain during intercourse?_____

Have you had any abnormal PAP testing? (If yes, please specify dates):_____

Number of pregnancies?_____ Number of live births?_____

Number of terminated pregnancies and reason for termination (still births, abortions, miscarriage, etc.)?_____

Do you have a history of pregnancy complications? Please specify:
_____

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Please specify below if any screenings have been completed to help us keep your preventative health a priority as a foundation of our practice.

TEST	DATE	LOCATION	ORDERING PROVIDER
COLONOSCOPY			
DEXA (BONE DENSITY)			
MAMMOGRAM			
PAP			
PSA (PROSTATE)			
ZOSTER VACCINE (SHINGLES)			
FLU VACCINE			
PNEUMONIA VACCINE			
SPIROMETRY (PULMONARY FUNCTION TEST)			
CHEST X-RAY			
EKG			
ECHO			
CARDIAC STRESS TEST			
PPD (TUBERCULIN SKIN TEST)			
DIABETIC FOOT EXAM			
DIABETIC EYE EXAM			
GENERAL EYE EXAM			

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FINANCIAL POLICY

Payment is due at the time that services are rendered. This includes outstanding balances, deductibles, co-payments, co-insurances and other fees for services not covered by your insurance company and expected charges for services rendered during your visit.

INSURED PATIENTS

- Prior to your visit (at check-in), an office visit fee, along with payment for all previously unpaid balances is collected. This includes copays, deductible and coinsurance balances, or any other
- If you are not sure what your insurance covers, PLEASE CALL YOUR INSURANCE COMPANY DIRECTLY! As the insured member, you are in the best position to get accurate information. As there are hundreds of insurance plans, we only provide a general cost estimate. In addition, the information given to us comes with a disclaimer that it may be inaccurate.
- As a courtesy, we assist with filing insurance claims, completing insurance forms, and requesting insurance pre-certifications.
- In short, the ULTIMATE RESPONSIBILITY for filing, processing, and paying claims remains with you. If your insurance has not paid their portion within ninety (90) days of being billed, we encourage you to continue contacting them in order to get your claims paid correctly and in a timely manner.
- You will receive regular statements requesting payment of any unpaid balance. After two (3) statements, your balance will be written off as bad debt and the debt will need to be resolved prior to scheduling your next appointment.
- We will collect full payment at the time of your visit for services rendered. If you have a deductible policy, please be advised that we will collect a minimum of $125 per visit depending on the verification of your insurance at the time of service.
- After seeing the physician / nurse practitioner (at check-out), there may be additional charges depending on the level of service that was provided by the physician or nurse practitioner and the additional services (labs, imaging, etc.) that may have been ordered / rendered during the visit.
- If additional testing is ordered after your visit and you anticipate a problem paying for these tests, please let our health care team know before leaving the office to discuss the next step.

PRIVATE PAY

- Prior to your visit (at check-in), an office visit fee, along with payment for all previously unpaid balances will be collected. All payment is required at the time of service.
- After seeing the physician / nurse practitioner (at check-out), there may be additional charges

depending on the level of service that was provided by the physician or nurse practitioner and the additional services (labs, imaging, etc.) that may have been ordered / rendered during the visit.
- If additional testing is ordered after your visit and you anticipate a problem paying for these tests, please let our health care team know before leaving the office to discuss the next step.

_____
Name of Patient

_____
Signature of Patient/Legal Representative

_____
Printed Name of Patient/Legal Representative

_____
Date

PATIENT PRIVACY RIGHTS

* To be afforded impartial access to treatment regardless of race, creed, sex, national origin, handicap condition, or age and be treated with respect and dignity at all times.
* To be interviewed and examined in privacy and to have someone of the patient's own gender present if requested.
* To refuse to talk with or see anyone not directly involved in the patient's care or treatment.
* To expect that his or her care and treatment be handled in confidence and that his or her medical record will be read only by authorized individuals.
* To expect complete and current information concerning his/her diagnosis (if known), treatment and prognosis is in understandable terms.
* You have the right to request a restriction on certain uses and disclosures or your information. However, the organizations listed above are not required to agree to a requested restriction.
* You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.
* You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.

* You may also request an amendment to your health record as allowed by state and federal regulations.
* You may also request communications of your health information by alternative means or at alternative locations. For example, by sending information to a P.O. Box instead of your home address.
* You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to ThrIVe Health and Wellness, 421 Page Place Road, Statesboro, GA 30458.
* You may also receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Health Information Management Department at the address listed above.

PATIENT RESPONSIBILITIES

* To provide accurate and complete information about your current complaints, past illnesses, medications, and financial status.
* To assure that the financial obligations of your healthcare are fulfilled promptly.
* To be considerate of the rights of others and assist us in controlling noise, the number of visitors allowed, and any other distractions that may influence patient care.
* To accept responsibility for all personal property and valuables brought into the office.
* To report any risks in your care and any unexpected changes in your health condition.
* To help the clinic improve services by providing feedback about your healthcare needs and expectations.

NO SHOW POLICY/LATE ARRIVAL/CANCELLATION POLICY

- We want your visit with us to be pleasurable. In order to do so and to minimize wait times, we have implemented a NO SHOW and LATE ARRIVAL/CANCELLATION POLICY. If you are more than 15 minutes late for an appointment, the appointment will need to be rescheduled. Please call our office if you know you will be late. If we are not able to answer, please leave a voicemail. If you do not show for an appointment or cancel less than 24 hours before your appointment, you will be charged a $25 fee and this must be paid before scheduling a new appointment. After three no show visits, you will be discharged from the practice.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

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_____ _____
Patient Signature Date

CONTROLLED SUBSTANCES

I understand that ThrIVe Health and Wellness will not prescribe or manage any **Narcotic** Medications such as Hydrocodone, Percocet, oxycodone or **any** other scheduled II narcotics. I understand that I will be referred to pain management for the management of these medication needs.

Patient Initials:_____

CONFIDENTIALITY

Absolutely no information about you or your treatment will be released to anyone without your written authorization or consent. In turn, we also ask that you respect the confidentiality of other patients by not discussing people you see in our office.
I have read a copy of the Notice of Privacy Practices and offered a copy (upon request). I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance or workman's compensation benefits.

Patient Initials:_____

IMMUNIZATION RECORDS

I authorize the Georgia Department of Community Health (or similar state or federal agency) to release any immunization records related to the above mentioned patient. Furthermore, I authorize ThrIVe Health and Wellness to release to the aforementioned agency notification of any immunizations I obtain through my treatment at ThrIVe Health and Wellness.

Patient Initials:_____

PRESCRIPTION RENEWALS

To the extent possible, we ask that you request prescription refills at the time of your visit. If you do need a refill, please call your pharmacy and they will contact us to refill your prescriptions. Please do not wait until you take your last pill before you call for a refill. To avoid running out of medication, please notify your pharmacy at least 48 hours in advance and please check with your pharmacist to see if your medication is ready.
For written prescriptions, please notify our office 2-3 days in advance when you need a refill.

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Patient Initials:_____

CANCELLATIONS

Your appointment is a specific period of time reserved just for you. If you need to cancel, we ask that you call our office 24 hours prior to your scheduled appointment time. Three NO SHOWS may result in termination from our practice and repetitive rescheduling in excess of normal request may result in termination from our practice. This policy is designed to help our office provide timely and efficient medical care.

Patient Initials: _____

LABORATORY

All labs will be sent to LabCorp Diagnostic Laboratory. All SELF-PAY patients will be responsible for the laboratory testing, charges, and fees, including drawing fee, at the time services are rendered. If your preferred lab is Quest or a local hospital, please inform our staff and we will accommodate all reasonable request.

Patient Initials:_____