Patient Registration

Contacts & Insurance

Contact Information

all contact info boxes are required

Legal Name:			Date of Birth:
Mailing Address:	City:	State:	Zip:
Phone:		SSN:	
Email:			
I would like automated appointment reminders: ☐ via text ☐ via email ☐ via phone call		It is okay to leave voicemails on my phone with sensitive clinical information: ☐ Yes ☐ No	

Insurance Information

Insurance Name:		
Policy #:	Group #:	
Subscriber Name:		Subscriber Date of Birth:
Subscriber Address:		
Subscriber Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other		Subscriber Phone:

Emergency Contact Information

☐ Same as Subscriber

Emergency Contact:	
Phone:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Address:	

I agree that this information is accurate to the best of my knowledge as of the date it was completed.

Patient Signature _____ Date _____

Printed Name _____

Medical History

Part One

DOB: Initials:

GENERAL HISTORY

List any current prescription, or over the counter medications you are taking:

List any supplements or over the counter vitamins you are taking:

List any allergies:

Date of last period:

Date of last PAP:

# of Pregnancies:

# of Kids (Living):

MEDICAL HISTORY (Mark all that apply)

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Murmur
- ☐ High Blood Pressure

Neurological
- ☐ Stroke
- ☐ Migraines
- ☐ Vertigo
- ☐ Concussions
- ☐ Seizures

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Strep Throat
- ☐ Sinus Problems
- ☐ Nose Bleeds (Frequent)

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Suicidal Thoughts

Hematological
- ☐ Anemia
- ☐ Clots
- ☐ Bleeding (excessive)
- ☐ Bruising (excessive)

Eyes
- ☐ Loss of Vision
- ☐ Glasses/Contacts
- ☐ Color Blind
- ☐ Cataracts
- ☐ Glaucoma

Endocrine
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ PCOS

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Itching (Frequent)
- ☐ Rash

Genitourinary
- ☐ UTI (recurring)
- ☐ STI/STD
- ☐ Kidney Problems
- ☐ Incontinence (urinary)
- ☐ Prostate Problems
- ☐ Frequent Urination
- ☐ Sexual Dysfunction
- ☐ Pain During Sex
- ☐ Heavy/Painful Periods

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Pneumonia

Gastrointestinal
- ☐ GERD/Acid Reflux
- ☐ Diverticulitis
- ☐ Diarrhea (Frequent)
- ☐ Vomiting (Frequent)

Musculoskeletal
- ☐ Fracture(s)
- ☐ Arthritis
- ☐ Artificial Joint(s)
- ☐ Back Pain

Immune
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ IBS
- ☐ Rheumatoid Arthritis
- ☐ Cancer

Other:

_____

Medical History

Part Two

DOB: Initials:

SURGICAL HISTORY

Procedure: Hospital/Clinic: Date:

FAMILY HISTORY

	Mom	Dad	Sister	Brother	Other
Diabetes	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

SOCIAL HISTORY

	Yes	No	How often?
Smoke/Tobacco	☐	☐	
Drink	☐	☐	
Recreational Drugs	☐	☐	
Caffeine	☐	☐	
Do you feel safe at home?	☐	☐	

Do you have a current/previous primary care provider?

If yes, who? _____

Name of Dr. Clinic Name Clinic Phone

When was your last annual exam? _____

HIPPA Compliance

Patient's Rights

This notice covers a patient's rights under the laws outlined by the Health Insurance Portability and Accountability Act (HIPAA). By signing this document, you acknowledge that you have read and reviewed this notice in its entirety and apply your consent.

The terms of this notice will be updated annually, at which time you will be asked to update your consent at the time of your next visit.

HIPAA allows for the use of Protected Health Information (PHI) for treatment, payment, and healthcare operations. We will not use or disclose any of your PHI for any reasons other than those allowed by HIPAA at any given time.

By signing this notice, you are consenting to the use and disclosure of you PHI to Power of Wellness Health Services (POW-HS). You have the right to revoke consent in writing, signed and dated by you, at any time. Any revocation will NOT be retroactive.

By signing this form, you agree and understand that:

- Protected Health Information can and will be used/disclosed for treatment, payment, and healthcare operations.
- POW-HS reserves the right to change the privacy policy as allowed by law and that you will be notified of any such changes.
- POW-HS will NOT disclose your PHI to any other facility or individual without your verbal or written consent or unless by court order.
- The patient has the right to revoke this consent in writing at any time, and that disclosure of PHI will cease at the time the facility is notified.
- Revocation of consent does NOT nullify any financial obligations you may have with POW-HS.

Would you be comfortable with us sharing or otherwise disclosing your PHI to family?

◯ Yes ◯ No If Yes, then who? _____

Signature _____ Date _____

_____

Printed Name

No-Show & Cancellation

Patient Acknowledgement

Power of Wellness Health Clinic has instituted an Appointment Cancellation Policy. A cancellation made less than 24 hour notice significantly limits our ability to make the appointment available for another patient in need. To remain consistent with our mission, we have instituted the following policy:

- Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
- A “No-Show”, “No-Call” or missed appointment, without proper 24-hour notification, may be assessed a $25 fee. This fee is not billable to your insurance.
    - Certain appointments require advanced preparation of supplies or medications that cannot simply be placed back into the stock supplies. Examples include, but are not limited to: cryotherapy, and certain injectable medications. There may be an additional $15 fee associated with these missed appointments.
- If you are 15 or more minutes late for your appointment, the appointment may be canceled and rescheduled. This is to ensure that you have the full time of your appointment with your provider to discuss your health concerns/goals.
- Repeated missed appointments may result in termination of the physician/patient relationship.
- As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received the cancellation policy remains in effect. Text and email notifications can also be arranged for you, as well as patient portal access where you can view your upcoming appointments and past appointment/lab info.

This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner and in a way that provides complete and excellent care.

To cancel or reschedule an appointment please call **POWER OF WELLNESS HEALTH CLINIC** at (907) 220-4747 and speak with the front desk. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you.

Please sign and date below your acknowledgment.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand that such terms may be amended from time-to-time by the clinic.

_____ _____

Patient Signature Date

_____

Printed Name

Payment Policy

Patient Acknowledgement

If You Are Covered by Insurance

Our office is currently credentialed with many local, state, and federal insurance programs. You MUST provide your insurance information/identification card at the time of your appointment. We will file all medical claims through our office. You are responsible for the annual deductible and co-payment as required by your insurance provider. You are required to pay the co-pay amount and or deductible cost upon check-out. If you do NOT have your insurance information at the time of your visit, you may be subject to CASH PAY.

If You Are NOT Covered by Insurance

We understand that many patients may not be covered by medical insurance. We do our best to ensure reasonable prices for those who are CASH PAY. We take major credit cards, debit cards, checks and cash. There is a $50 fee for all returned/bounced checks. Returned checks must be recovered within ten (10) days. If a check is returned more than once by a patient and/or guarantor, then all payments thereafter MUST be by credit card or cash.

Credit and Collection Policy

Power of Wellness Health Services requires that all balances must be paid at time of visit unless otherwise arranged. We will do our best at keeping you. informed of your healthcare costs as services are rendered. If there is a balance on your account after your insurance has been billed, you will be responsible for the remaining payments. We will consult with our billing department over any outstanding balances prior to sending any patient to collections.

By signing this document, I hereby consent to the Payment Policy as outlined above:

_____ _____

Signature Date

_____

Printed Name