

**Patient Demographics**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | | Middle Name: |
| Birth Date − Month / day / year: | Social Security Number: | | Sex: |
| Address: | City: | State & Zip: | |
| Home Phone: | Cell Phone: | Email: | |

**Parent / Guardian if applicable**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | | Relationship: |
| Address: | City: | State & Zip: | |
| Email: | Cell Phone: | Work Phone: | |

**Single Married Divorced Separated Widowed**

**Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Languages spoken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment Source:  Insurance  Self-pay**

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Insurance: | | Secondary Insurance: | |
| Subscriber Name: | Employer Name: | Subscriber Name: | Employer Name: |
| Policy #: | | Policy #: | |
| Group #: | | Group #: | |
| Phone: | | Phone: | |

**Guarantor:**

|  |  |  |
| --- | --- | --- |
| Name: | Phone: | Email: |
| Address: | City: | State & Zip: |

**Primary Physician:**

|  |  |  |
| --- | --- | --- |
| Physician Name: | Phone: | Fax: |
| Address: | City: | State & Zip: |

**Employment:**

|  |  |  |
| --- | --- | --- |
| Employer Name: | Phone: |  |
| Address: | City: | State & Zip: |

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the provider/person/facility/entity listed below.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

Complete Records History & Physical Progress Notes

Care Plan Lab Reports Radiology Reports

Pathology Reports Treatment Record Operative Reports

Hospital Reports Medication Record Other (specify below)

**Release my protected health information to the following provider/facility and/or those directly associated with my medical care:**

Name: Infinity Wellness Phone Number: 501-701-9395

Address: 1558 Airport Rd. Ste. E Fax Number: 501-246-7037

City: State: Zip Code: Hot Springs, AR 71913

The purpose/reason for this release of information is as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Printed Name of Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Social Security Number Signature of Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Description of Personal Representative’s Authority

Patient HIPAA Acknowledgement and Consent Form

Clinic: **Infinity Wellness** Provider:  **Emily Way, APRN**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we identify ourselves over the phone? YES / NO May we leave messages: YES / NO

Patient Representative (Parent or Guardian if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

**(Patient/Representative initials \_\_\_\_\_\_)** I acknowledge that I have received the clinic’s Notice of Privacy Practices, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the INFINITY WELLNESS Privacy Officer if I have a question or complaint. I understand that this information may be disclosed electronically, in print, phone, or fax by the Provider and/or the Provider’s business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the clinic’s Notice of Privacy Practices.

**Disclosures to Friends and/or Family Members**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, LIST BELOW.** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME RELATIONSHIP CONTACT NUMBER

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Communication about My Healthcare**

I agree the Provider or an agent of the Provider or an independent physician’s office may contact me for the purposes of scheduling necessary visits related to my healthcare as recommended by the treating healthcare provider.

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice’s/clinic’s health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications**

**If at any time I provide an email address or cellphone number** at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Note:** This clinic uses an Electronic Health Record that will update **all your demographics and consents** to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

**Release of Information**

I hereby permit practice/clinic and the providers or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

* Healthcare information regarding a prior service(s) at other affiliated providers may be made available to subsequent affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.
* If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
* Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS, medical conditions and aesthetic/elective treatments or procedures.

I certify that I have read and fully understand the statements from all pages and consent fully and voluntarily to its contents.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and my no longer be protected by federal or state law.

A photocopy of this consent shall be considered as valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative (Parent/Guardian if applicable) Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness (Employee)/ Job Title Date

**INFINITY WELLNESS General Consent for Care and Treatment**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, a nonspecific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

This consent also gives this office permission to electronically receive your prescription record from your pharmacy and other sources, including the Arkansas Prescription Monitoring Program.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the testing or procedure(s).

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

**Signature of Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Personal Representative**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness (Employee)/ Job Title**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFINITY WELLNESS Patient Financial Responsibility Policy**

*Our goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.*

The patient’s insurance policy is a contract between the patient and his or her insurance company. However, **all charges regardless of the insurance coverage are the patient’s responsibility** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, INFINITY WELLNESS bills the patient’s insurance and makes every effort to ensure that claims are promptly and correctly processed. INFINITY WELLNESS also bills patients’ secondary insurance when patients provide complete insurance information. Patient co-pays are expected at the time of service, and any remaining payment is due within 30 days of receiving the first bill from INFINITY WELLNESS. We accept cash, debit cards and credit cards (Visa, Master Card, Discover). If you are not able to pay your balance within 30 days, please contact our Billing Office at (501) 701-9395. There are several ways you can pay your bill, including possible payment plans and a Billing Office representative will help find the right one for your financial needs.

1. **Past Due Balances**  
   A past due balance is any amount owed after the insurance company has paid its portion, but where INFINITY WELLNESS has not received the full patient balance within ninety (90) days. After ninety (90) days as a private pay balance, interest may accrue at the rate of 1.0% per month (12% annual rate) on the unpaid balance at the discretion of the practice. Balances on accounts with payment plans where payments are in compliance with the plan are not considered past due balances.
2. **Payment Plans**  
   Payment arrangements may be made on patient’s accounts based on a review of circumstances and approval by the INFINITY WELLNESS Billing Office. We generally do not extend payment plans to patients who have failed to make timely payments in the past. INFINITY WELLNESS’s Billing Office representatives may authorize monthly installment payments following the practice’s minimum payment guidelines below.

|  |  |
| --- | --- |
| **Account Balance** | **Minimum Monthly Payment** |
| $100 or less | $10.00 |
| $250 or less | $25.00 |
| $251 - $500 | $45.00 |
| $501 - $750 | $65.00 |
| $751 - $1000 | $85.00 |
| Over $1,000 | 10% |

1. **Waiver of Co-Pays and Past due balances**
   1. It is the policy of this practice to bill all applicable out of pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. INFINITY WELLNESS will not waive co-pays or coinsurance amounts for insured patients, except in limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare*.
   2. If INFINITY WELLNESS does waive co-payments or past due balances for a patient based on the patient’s financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and past due balances may also be made after reasonable collection efforts have failed to result in the collection of fees. INFINITY WELLNESS will maintain records of what collection efforts have been made for fees waived in these instances.
   3. Under no circumstances will our practice engage in any of the following practices with respect to the waiver of lowering of co-insurance and/or past due balances:  
      -Waive or lower co-insurance and past due balances that do not meet the requirements outlined in our Policy.
   4. Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for health care services provided by our practice or advertise or otherwise communicate to our patients or to the general public that patients will incur no out of pocket expenses.
   5. Routinely use financial hardship forms which state that the patient is unable to pay co-insurance and past due balance amounts.
   6. Charge Medicare beneficiaries or private insurance beneficiary’s different amounts than those charged to other persons for similar services.
   7. Fail to collect co-insurance and past due balances from a specific group of patients for reasons unrelated to indigence or managed care contracting (e.g., to obtain referrals or to induce patients to seek care in my practice vs. another provider’s practice who does not waive co-pays and/or past due balances).
   8. Accept “insurance only” or TWIP (take what insurance pays) as payment in full for services rendered.
   9. Fail to make reasonable collection effort to collect a patient’s balance.
2. **Financial Hardship Determinations**

For indigent, uninsured or underinsured patients, may reduce or eliminate the patient’s financial responsibility for medically necessary and appropriate treatment on a case by case basis where the patient qualifies under our financial hardship guidelines. Financial hardship determinations are based upon a review of household income, assets and liabilities in relation to current Federal Poverty Income Guidelines. As part of the process, we generally evaluate income levels, net worth, employment status, other financial obligations, the amount and frequency of healthcare bills, and other circumstances. The determination of financial hardship is applicable to the current episode of care. To waive or reduce further payments, the patient must again prove financial hardship. The patient and the Billing Office representative shall sign a statement detailing that the practice has reviewed proof of financial hardship, and what bills are being reduced or waived.

1. **Applying for Financial Hardship Assistance**

The patient or responsible party must request and complete a Patient Financial Hardship Application and sign the form.  
Submit the completed worksheet and any supporting documentation (e.g., W-2s, Federal tax return, pay stubs, etc.) to our Billing Office for review. We will review your package upon receipt and contact you if additional information is required. Applications will not be approved for financial hardship assistance when required forms are incomplete or necessary documentation is missing. We will contact you regarding your application, generally within 5 business days after we receive your complete application and all required attachments. The representative will inform you of our decision regarding your request for financial assistance and, if applicable, the level of discount for your outstanding INFINITY WELLNESS bill.

**\*\*I HAVE READ, UNDERSTAND, AND AGREE TO INFINITY WELLNESS FINANCIAL RESPONSIBILITY POLICY** **AND GRANT PERMISSION TO INFINITY WELLNESS TO FILE INSURANCE CLAIMS ON MY BEHALF.**

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient representative signature (parent or guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness (Employee)/ Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFINITY WELLNESS PATIENT RIGHTS & RESPONSIBILITIES

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:  
 ***You have the right to:***

* A personal clinician who will see you on an on-going, regular basis.
* Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
* A second medical opinion from the clinician of your choice, at your expense.
* A complete, easily understandable explanation of your condition, treatment and chances for recovery.
* The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
* Confidential management of communication and records pertaining to your medical care.
* Information about the medical consequences of exercising your right to refuse treatment.
* The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
* Be free from mental, physical and sexual abuse.
* Humane treatment in the least restrictive manner appropriate for treatment needs.
* An individualized treatment plan.
* Have your pain evaluated and managed.
* Refuse to participate as a subject in research.
* An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
* The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
* The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.
* A Physician evaluation for medical care. (APRNs staff INFINITY WELLNESS. The employees of INFINITY WELLNESS can assist in arranging a physician evaluation.)

***You are responsible for:***

* Knowing your health care clinician’s name and title.
* Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
* Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
* Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
* Signing a “Release of Information” form when asked so your clinician can get medical records from other clinicians involved in your care.
* Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
* Telling your clinician about any changes in your condition or reactions to medications or treatment.
* Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
* Following your clinician’s advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
* Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
* Paying copayments at the time of the visit or other bills upon receipt.

INFINITY WELLNESS PATIENT AGREEMENT

Payment is due at time services are rendered.

By signing below, you agree to and understand the following policies:

* HIPAA – Privacy Notice I am aware that I may review Infinity Wellness’s (INFINITY WELLNESS) HIPAA privacy notice at any time and understand that I may request a copy. Any questions, concerns that I may have may be directed to the INFINITY WELLNESS HIPAA PRIVACY OFFICER and my APRN at INFINITY WELLNESS. \_\_\_\_\_\_\_\_\_\_\_\_\_ Initials
* Medical Care Agreement-- I authorize the employees of INFINITY WELLNESS to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that INFINITY WELLNESS is not responsible for verifying insurance coverage or benefits. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits that would otherwise be payable to me, to Infinity Wellness, LLC. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials
* Medical Care Agreement-- I authorize the APRNs at INFINITY WELLNESS to practice within their scope of practice according to the ASBN Nurse Practice Acts to provide certain aspects of my medical care. I understand that INFINITY WELLNESS is staffed by APRNs. I understand that a Nurse Practitioner (APRN) is not a licensed physician. APRNs work in collaboration with supervising physicians for consultation if needed. I acknowledge it is my responsibility to inform the staff of INFINITY WELLNESS if I wish not to see the Nurse Practitioner and the staff will assist me in getting an appointment with a physician as necessary. \_\_\_\_\_\_\_\_ Initials
* Electronic Communication-- By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials
* I understand the clinic normally uses American Esoteric Laboratories (AEL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by AEL, instead of another lab. I will be responsible for the payment and insurance filing/reimbursement of my preferred lab \_\_\_\_\_\_Initials
* I understand there can be a fee for controlled substance prescriptions written without an appointment. ($25), Most controlled prescriptions require regular appointments for evaluation and management. \_\_\_\_\_\_\_\_Initials
* I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment. The fee is ($25)\_\_\_\_\_\_\_\_Initials
* I understand there is a $35 fee for bounced checks and an additional $20 processing fee for balances that go in to collections. \_\_\_\_\_\_\_Initials
* I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed. \_\_\_\_\_\_\_Initials
* I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed. I understand that INFINITY WELLNESS APRNs/delegates will utilize the AR PMP service in accordance to Act 820 and may be utilized as deemed necessary for compliance, safety concerns, or for verifying controlled RXs. I agree to the INFINITY WELLNESS Controlled Substance Policy. \_\_\_\_\_\_\_\_\_Initials
* I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the APRN. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results. Fees for Services: $25 Controlled substance prescriptions without an appointment, $35 Attending provider statement, $50 APRN dictated letter, $75 APRN narrative. Thank you for your cooperation. \_\_\_\_\_\_\_\_Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative (Parent/Guardian if applicable) Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness (Employee)/ Job Title Date

**New Patient History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ft \_\_\_\_\_\_\_\_\_\_in Translator Required: YES NO

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| Please list other Doctors you see: |
| Please list any allergies: |

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| **PAST MEDICAL HISTORY** | **YES** | **NO** |  | **PAST MEDICAL HISTORY** | **YES** | **NO** |  | **PAST MEDICAL HISTORY** | **YES** | **NO** |
| Acid Reflux |  |  | High Blood Pressure |  |  | Seizure Disorder |  |  |
| Anxiety |  |  | High Cholesterol |  |  | Stroke |  |  |
| Asthma |  |  | Enlarged Prostate |  |  | Seasonal Allergies |  |  |
| Bipolar Disorder |  |  | Heart Attack |  |  | Substance Abuse/Alcoholism |  |  |
| Blood Clot (DVT/PE) |  |  | Heart Valve Problem |  |  | Thyroid Problem |  |  |
| Cancer |  |  | Hepatitis |  |  | Tuberculosis |  |  |
| Chronic Pain |  |  | Hemophilia (Free Bleeder) |  |  | Other: | | |
| COPD |  |  | Kidney Disease |  |  | Other: | | |
| Coronary Artery Disease |  |  | HIV/AIDS |  |  | Other: | | |
| Crohn’s/Ulcerative Colitis |  |  | Migraines |  |  | Other: | | |
| Depression |  |  | Peripheral Artery Disease |  |  | Other: | | |
| Diabetes |  |  | Rheumatoid Disease |  |  | Other: | | |

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| **SURGICAL HISTORY YEAR YEAR** | | | | | |
|  | Appendix Removed |  |  | Hernia Repair (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |
|  | Back Surgery |  |  | Hysterectomy |  |
|  | Bladder Surgery |  |  | Ovaries Removed |  |
|  | Cataract |  |  | Orthopedic Surgery |  |
|  | C-Section |  |  | Tonsils Removed |  |
|  | Ear Tubes |  |  | Tubal Ligation |  |
|  | Heart Catheterization |  |  | Vasectomy |  |
|  | Gallbladder Removal |  |  | Other: |  |
|  | Heart Bypass |  |  | Other: |  |

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| **FAMILY HISTORY: Check which family members have had the following** | | | | | | |
| None Mother Father Sister Brother Other:specify | | | | | | |
| Cancer (Type: ) |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Substance Abuse/Alcoholism |  |  |  |  |  |  |
| Other (Specify: ) |  |  |  |  |  |  |

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| **ADVANCED DIRECTIVE/LIVING WILL** |
| Do you have an advanced directive/living will? YESNO |
| If yes, please give a copy to the front desk. |
| If no, would you like more information? YESNO |
| **SOCIAL HISTORY** | |
| Single Married Divorced Separated Widowed | |
| I have never been sexually active. I am currently sexually active.  I am not currently sexually active. | |
| Do you have children? Yes  No Number of children \_\_\_\_\_\_\_\_\_\_ Do you have custody?  Yes  No | |
| **Job Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired  Disabled (Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| **Tobacco Use** NoneQuit (date) \_\_\_\_\_\_\_\_\_\_\_\_ Still use: Cigarettes Smokeless/Chew Cigars Pipe  Check the amount of tobacco you use(d) each day. 1/2 pack/can 1 pack/can  How many years did/have you smoked? \_\_\_\_\_\_\_\_\_\_\_ 2 packs/cans More  Do you use e-cigarettes/vape/JUUL? YESNO | |
| **Alcohol Use** None (A drink is 1 shot of liquor, 1 glass of wine, or one bottle/can of beer) 1-5 drinks/**MONTH**  1-4 drinks/**week** 5-7 drinks/**week** 8-10 drinks/**week** 10-14 drinks/**week** More than 2 drinks/**day** | |
| **Drug Use** YESNOQuit (date) \_\_\_\_\_\_\_\_\_\_\_\_ If yes, what do you use regularly?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **HIV/AIDS Screening** YESNO If yes, where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **HEALTH MAINTENANCE** |
| Do you wear seatbelts? Always SometimesNever |
| Have you seen a dentist in the last year? YESNOIf yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of your last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last bone density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of your last pneumonia shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last tetanus shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of your last shingles shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last flu shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **WOMEN ONLY Last Period Date: OR Age of Menopause:** |
| Current birth control: NONE BC Pills Depo Shot IUD Nuvaring Patch Tubal Ligation Partner Vasectomy  Number of pregnancies: \_\_\_\_\_\_\_\_\_\_ Number of live births:\_\_\_\_\_\_\_\_\_ Number of miscarriages:\_\_\_\_\_\_\_\_\_  Date of your last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had an abnormal pap smear? YESNO  Date of your last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had an abnormal mammogram? YESNO |

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| **CURRENT MEDICATIONS \*\*If you need more lines, please request another form.** | | | |
| None | | | |
| Name of Medication | Strength (mg) | How Often | Reason for Medication |
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Name of person completing form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_