Advanced Health and Wellness

3729 N. Crossover Rd. Suite #107
Fayetteville, AR. 72703
Phone: 479-595-8676
Fax: 479-935-8984

Diana Holte, APRN Kellie Chacanaca, APRN

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is **NOT** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number : _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

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PATIENT INFORMATION – Please Print

Date:_____

Name (Last, First, MI)_____

Gender: __ M __ F Date of Birth _____SSN _____-_____-_____

Address:_____Apt#_____

City:_____ State:_____ Zip_____

Home Phone:_____ Cell _____

Preferred Contact: (circle one) Home Work Cell Email_____

Employer: _____ Work Phone: _____

Marital Status: (circle one) **Single Married Widowed Divorced Partner**

Race: (circle one) **White African American Asian Native Hawaiian/Pacific Islander**
Native American Indian/Alaskan Other Race: _____
Preferred Language:_____

Local Pharmacy:_____

Mail Order Pharmacy: _____

How you would like to be notified of your appointment. You may select more than one option?
(circle one) Email Text Phone Call
*Messages and data rates may apply for text messages.

SPOUSE or PARENT (if minor) INFORMATION

Name: _____ Date of Birth_____Social Security _____

Employer _____Address_____Phone _____

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____Relationship _____

Phone_____Address_____City_____State____Zip _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Do you want a copy of the Patient Notice of Privacy Practices from Advanced Health and Wellness? YES NO

SIGNATURE _____DATE _____ In the event this acknowledgment form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number, and relationship to the patient.

PERSON RESPONSIBLE PARTY FOR PAYMENT

Myself/My Spouse OR list Father/mother/Guardian/other

Name:_____ DOB: _____
Address:_____Apt#_____
City:_____State:_____ Zip:_____

HEALTH INSURANCE INFORMATION

Medicare Medicare No. _____-_____-_____-_____ **Effective Date** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Health and Wellness for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

PRIMARY INSURANCE_____
ID #_____ GP#_____Phone# _____
Policy Holder's Name_____ DOB_____ SS#_____
Relationship to Policyholder: (Circle one) Self Spouse Child Step-Child Other:_____

SECONDARY INSURANCE_____
ID#_____GP#_____Phone# _____
Policy Holder's Name_____ DOB_____ SS#_____
Relationship to Policyholder: (Circle one) Self Spouse Child Step-Child Other:_____

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Advanced Health and Wellness to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. I agree to pay any co-pay and amount due at the time of service. Further, I agree to be responsible for any and all cost of collection to include court costs and a reasonable attorney fee.
Signed _____Date _____

HOW DID YOU HEAR ABOUT US?

- Recommended by a friend or family member
- Clinic website, www.advancedhealthnwa.com
- E-mail, Facebook or Twitter
- Signs or location
- Other: Please specify _____

Thank you for choosing Advanced Health and Wellness

Please complete the information below to help your doctor evaluate your health.

Name _____ Date_____ Date of Birth_____

Why are you visiting the doctor? _____

Do you feel that you are basically healthy? *(cirlce one)* **Yes** **No** What is bothering you? _____

Mark any diseases known to have occurred in the family with the appropriate initial: M (Mother), F (Father), MGM (maternal grandmother), PGM (paternal grandmother), MGF (maternal grandfather), PGF(paternal grandfather) , A (aunt), U (uncle), C (cousin), B (brother), S (sister).

Alzheimer		Cancer		Hearing Prob.		Obesity	
Asthma		Stroke		Cholesterol		Blood Clots	
Alcoholism		Depression		High Blood Pressure		Kidney Prob	
Blood Disease		Developmental Problems		Mental Disease		Seizures	
Coronary Artery Dis		Diabetes		Migraines		Sickle Cell	

About You:
Education:*(circle one)* **Elementary** **High School** **GED** **College** **Graduate School** **Tech School**

Occupation_____*(circle one)* **Single** **Married** **Widowed** **Divorced**

Tobacco Use: Type: *(circle one)* **Cigarettes** **Smokeless Tobacco**

Current -Everyday, how much?_____ Current -occasional, how much?_____
Former, how much?_____ Year started_____ Year Quit_____ Never _____

Alcohol Use: *(circle one)* **Yes** **No** Formerly How much and often? _____

Illicit drug use:*(circle one)* **Yes** **No** Formerly Please list_____

Allergies: Medicines _____Other _____

Medications: *Please list medications you take regularly.*
Over the Counter (Include vitamins and supplements) :_____
_____

Prescription: _____
_____
_____
_____

Your Health History

Medical Conditions: _____
_____
_____

Operations *(Please include where and when)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please mark "yes" to anything you have experienced recently or frequently:

	Y	N	When		Y	N	When
General:				***Gastrointestinal:***			
Feel anxious, depressed, or irritable							
Nervous breakdown				diarrhea			
Fever, Chills, Night Sweats				Frequent indigestion or gas			
Skin:				***Genitourinary:***			
Skin Rashes				Blood in urine			
Eyes, Ears, Nose, Throat:				Burning when you pass urine			
Severe or frequent headaches				Sexually transmitted disease			
Hearing trouble				***Musculoskeletal:***			
Goiter or thyroid trouble				Arthritis			
Vision trouble				**Health Changes:**			
Respiratory:				Has your weight changed in the past year?			
Shortness of breath				Approximate weight 1 year ago_____			
Asthma				***Other:***			
Cough				Excessive thirst			
Cardiovascular:				Swollen glands			
Heart trouble Pain in chest				Hay fever or allergies			

For Women

Are you currently pregnant? *(circle one)* **Yes** **No** Pregnancies(#):_____ Miscarriages:_____

Living children:_____ Age when menstrual periods began _____

Patient Signature_____**Date**_____