WellQuest
MEDICAL CLINIC AND SPA

Date Revised: 10-19-2006 [br]

REGISTRATION FORM

Today's date:	Your PCP:
** **I understand that payment in full is expected at the time services are rendered. My insurance may be billed.** Initial ______ (client)	

CLIENT INFORMATION

Last name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( ) Cell phone no.: ( )

PO Box:	City:	State:	ZIP Code:

E-mail address: ______ ❑ **YES!** Please add me to the mailing list.	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

Preferred pharmacy: (Name/Location)	Reason for your visit today:

INSURANCE INFORMATION (Our Medical Administrative staff will need your insurance card.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a client here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance? ❑ Yes ❑ No

Primary Insurance:	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize WellQuest or my insurance company to release any information required to process my claims.

Client/Guardian signature ______________________ Date ______________

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

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HEALTH HABITS AND PERSONAL SAFETY					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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MENTAL HEALTH				
Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No

WOMEN ONLY				
Age at onset of menstruation:				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Number of pregnancies _____ Number of live births _____				
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Date of last pap?				
Date of last mammogram?				

MEN ONLY				
Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Has the force of your urination decreased?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Date of last prostate and rectal exam?	☐	Yes	☐	No

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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PATIENT NOTICE OF OUR PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received a copy of the "Patient Notice of Our Privacy Practices" from
WellQuest Medical Clinic and Northwest Arkansas Primary Care Physicians, PA.

Please print

Client name ____ DOB _________________________

Signature ____ Date _________________________

Returned checks will be assessed a $25 fee. _________ (initial)

In the event this form is being executed by a personal representative, parents, or guardian, please print your name and relationship to the client.

Name ____ Relationship ____________________

DOB _________________________

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Date Revised: 09-24-2006 [md]

Patient Notice of Our Privacy Practices

Please review the following notice that describes how medical information about you may be used and disclosed and how you may get access to this information.

This is NWA Primary Care Physicians ("Clinic's") notice to you of how certain health information regarding you may be used or disclosed by this Clinic. We are required by law to provide you with a description of our privacy practices. Should you have any questions concerning this Notice contact the Privacy Officer named below:

- The effective date of this Notice is April, 2003. You will be provided, either by mail or in person with a copy of any amendments or changes to this Notice.
- This Notice should be delivered to you no later than the date of the first encounter with you as a patient or, in an emergency situation, as soon as possible after the emergency treatment situation.
- This Clinic is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to your protected health information.
- Should you believe that your privacy rights have been violated, you have the right to file a complaint with the privacy Officer or with the Secretary of Health and Human Services at the address set forth below. Complaints should be in writing with a description of the events under which you believe your privacy rights were violated. Please give us as much detail as possible in you complaint. This will help us investigate your complaint. It is our policy not to retaliate against any patient for filing a complaint involving a violation of their privacy rights.

Privacy Practices

Disclosure of Your Health Information by Us

We may use or disclose your protected health information for purposes of treatment, payment or healthcare operations without your consent or authorization. This information may be transmitted by electronic transmission, by fax transmittal or by e-mail.

Treatment "Treatment" is defined by the Department of health and Human Services in its Privacy Standards as "...provisions, coordination, or management of health care or related services by one or more health care providers ... " This means that for our own purposes we may use or disclose protected health care information among our employees and other staff professionals of the Clinic for the purpose of treating your medical condition. Furthermore, we may disclose your protected health information to other health care providers if we make a referral or if we seek consultation or review by another health care provider. An example of treatment might include a situation where your treating physician orders blood work or other types of diagnostic tests. The results of these tests might be reviewed by different professionals or caregivers and their conclusions would be used to assist in determining the appropriate therapies or plan of care for your treatment.

Payment "Payment" is a rather broad term. An example of a "disclosure or use of protected health care information" for payment purposes would be submitting a claim to your insurance carrier so as to be reimbursed for our services. Other examples include activities such as determining eligibility of coverage under your insurance plan or answering questions by your insurance company so as to determine whether there was a medical necessity for the procedure or diagnosis performed by us or at our direction.

Health Care Operational The final category under which we may use or disclose your protected health information without your permission is for activities performed by us such as quality assessment, case management and care coordination, contacting other providers about care alternatives for you, conducting internal training programs for supervisory purposes, and activities associated with the licensing and issuance of credentials for our staff.

Our Contacts with You

Periodically, we will issue appointment reminders, provide follow-up information on treatment alternatives, and possibly offer other treatment-related services to you. Typically, we conduct these contacts by mail and telephone. If you do NOT wish us to leave messages on your telephone answering machine or to receive mail at your residence, contact us. You do have the right to ask us to contact you in a confidential manner and we will do our best to accommodate you.

Disclosure to Others

You will be asked to sign an authorization if you wish us to disclose your protected health information to others and the disclosure is for something other than payment, treatment or health care operations. You will always have the right to revoke an authorization at any time, except to the extent this Clinic or any other providers have already taken an action in reliance upon your authorization.

Disclosures Without Your Consent or Authorization Under Arkansas law, there are specific conditions or events that must be disclosed to third parties or state agencies whether or not you authorize this use or disclosure. These categories include:

(a) Incidents of suspected child abuse;
(d) Sexual assaults;
(e) Knife or gunshot wounds;
(f) Domestic Violence; and
(g) Sudden death of child.

In addition, Clinic participates in clinical research studies, which may involve your treatment. From time to time, we review our patients' protected health information to determine if they are suitable candidates to participate in clinical research trials. Before we will enroll you in such a research program or disclose your protected health information to third parties conducting clinical research trials, we will obtain your express authorization.

Your authorization, will, among other things, contain:

(a) A description of the extent to which your protected health information will be used or disclosed to other persons; and
(b) A description of any protected health information that will not be used or disclosed for purposes of or use in the clinical research trial.

As with any other authorization, you may revoke this authorization at any time and ask that your protected health information no longer be used as part of the clinical research trials.

Patient Individual Rights

You have the following rights which may be exercised by you at any time:

(a) The right to request restrictions on certain use and disclosure of your protected health information. However, please note that we will not be required to agree to these restrictions, particularly if, in our opinion, they interfere with treatment, payment, or other health care operations. However, we are willing to work with you in good faith to implement any restrictions you request. Should we disagree with the restrictions you place upon us, we will notify you in writing and suggest alternatives including seeking another health care provider.
(b) You have the right to receive communications from us in a confidential manner as noted above.
(c) You have the right to inspect a copy of your health information in our file at any time.
(d) You have the right to amend incorrect or incomplete information or to provide a statement as to the reasons you believe the amendment regarding incorrect or incomplete information should be included in your file. However, we are not able to amend or alter health information about you we receive from another health care provider.
(e) You have the right to receive an accounting from us of all disclosures of your protected health information made to third parties other than for treatment, payment, or health care operations purposes. However, this accounting will be subject to certain restrictions and limitations as set forth below.

Restrictions with Regard to Accounting

Your right to an accounting will not include the matters set forth below. An accounting with regard to your personal health information will NOT include the following items:

- Internal use by us of your information for treatment, payment or health care operations purchases.
- Disclosures made to you by us or at your request (or the request of your personal representative) to third parties.
- Disclosures made by you to our answering service or directory service when you contacted us after hours.
- Disclosures made to family members or friends in the course of providing care to you.
- Disclosures to correctional institutions.
- Disclosures made by us for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure by us for a specified period of time.
- Disclosures made to the Department of Health and Human Services, if you have filed a complaint with that organization believing that your privacy rights have been violated.
- Your right to receive a paper copy of this Notice, even if you have previously agreed to receive this Notice electronically.

Questions & Concerns

For more information or to file an Internal complaint, contact the Privacy Officer.

Privacy Officer
3400 SE Macy, Suite 18
Bentonville, AR 72712
Phone: (479) 845-0880
Fax: (479) 845-0887

The Privacy Officer listed above can provide you with the appropriate address for the United States Department of Health & Human Services