COMPLETE Wellness
MEDICAL + CHIROPRACTIC

Patient Demographic Information Form

Please fill out every space, if it does not apply to you, please write N/A, for not applicable.

Patient Information:

Patients Name (Last, First, Middle) (Suffix) (Preferred) (Former Last Name)

_____

If patient is a minor, list names & contact information for Parents (Step)/ Guardians

(Lat, First, Middle Initial) (Address) (Phone) (Relationship)

_____

_____

_____

Sex: ☐ Male ☐ Female **Date of Birth:**_____ **Soc Sec #:**_____ **Marital Status:** Single

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Mobile Phone:** _____ **Work Phone:** _____

Patient Email: _____

Preferred Language: _____ **Race:** _____ **Ethnicity:** ☐ Hispanic ☐ Not Hispanic

Provider Information:

Primary Care Physician: _____ Phone #: _____

Communication:

☐ I authorize Complete Wellness, and those parties acting on behalf of Complete Wellness, to contact me about appointments and reminders for health services via: ☐ **Home Phone** ☐ **Mobile Phone** ☐ **Email**

Is it OK to leave medial information on your answering machine or voice mail? ☐ **YES** ☐ **NO**

Patient Photos- (Photos may or may not be a part of your patient care)

☐ **I DO** or ☐ **I DO NOT** give consent for photos of me for identification and or treatment purposes. _____ **Initial**

Emergency Contact Information:

Name: _____ Relationship: _____ Mobile #: _____ Home #: _____

Name: _____ Relationship: _____ Mobile #: _____ Home #: _____

Employment:

Employers Name: _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Guarantor (Name to Whom Statement are sent for Minors)

Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Social Security #:** _____

Insurance:

Primary Insurance Company: _____ **Subscribers Name (Policyholder)** _____

Subscribers DOB: _____ **Subscribers Soc Sec #:** _____ **Relationship to Subscriber:** _____

Secondary Insurance Company: _____ **Subscribers Name (Policyholder)** _____

Subscribers DOB: _____ **Subscribers Soc Sec #:** _____ **Relationship to Subscriber:** _____

Clinical Information:

Preferred Pharmacy: _____ **Preferred Lab:** _____

Financial and Treatment Consent:

By signing my name below:

- I hereby guarantee payment in full within thirty (30) days of all charges established by Complete Wellness for services rendered to me or my dependent unless other arrangements satisfactory to Complete Wellness have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits.
- I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third-party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees.
- I authorize Medicare, Medicaid, all relevant commercial payers to pay Complete Wellness on my behalf for any service furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all the provisions contained in it.
- I understand that if I am facing financial difficulty, I can set up a payment plan with Complete Wellness.
- The insurance information that I have provided id current and correct. If I sign this form and the insurance card if found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.
- I hereby consent to treatment by my Complete Wellness Provider(s). I understand that Complete Wellness will release my referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continuing care and as needed to process claims and for general health care operations. I agree that this consent is valid for all treatment and payment of said treatment for a period of twelve (12) months following execution of the consent.
- I understand my insurance co-pay is due at time of service, per my insurance company policy.

I ACKOWLEDGE RECEIPT OF PRIVACY PRACTICES: _____ **(Patient Initials)**

_____

Patient/Guardian Signature **Date**

****OFFICE USE ONLY** NPP Witness/Issued by:** _____

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Patient Consent to Share Protected Health Information

This form will allow us to leave a message on voicemail or with individuals involved in your health care

Patient Name:	Phone Number:
Date of Birth:	Social Security #:

I (the undersigned) hereby consent to Complete Wellness leaving a voicemail message at the number(s) indicated above and/or discussing the individual(s) listed below information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, billing and insurance items, and any information pertaining to clinical health services, such as laboratory and test results. I understand that this consent is only valid at the office location listed above.

With my consent Complete Wellness may discuss my PHI with the following individuals:

Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship:	Phone #:
Name:	Date of Birth:
Relationship:	Phone #:

I understand the information listed above may be communicated via fax, photocopy, verbal communication, telephone, voice mail and/or direct mail.

If certain information is not to be included, please list: _____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:
I understand that I have the right to revoke this consent at any time by sending a written statement to Complete Wellness, except to the extent Complete Wellness had already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration date listed below. A photocopy of a signed consent is acceptable, provided that is apparent that the consent was signed and dated prior to photocopying.

I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate validation authorization.
If I fail to specify an expiration date, event, or condition, this consent will be valid for one year. _____
Expiration Date/Event/Condition

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
(If signed by Legal Representative, state relationship and authority to do so) Date

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Authorized Legal Representative ☐ Executor of Estate of Deceased

Received By: _____ **Date:** _____

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Medical Records Release Form

(Entire Record)

Patients Name_____

Date of Birth_____

SSN_____

Please release my medical records from the following Provider/facility:

Name_____

Address_____

City, State, Zip_____

Phone #_____

Fax #_____

The release of records is for continuation of care to:

Kelli Brown, FNP
602 Main Street
Tell City, IN 47586
Ph 812.772.2300
Fax 812.772.2313

Megan Harth
35 Joshua Lane
Hawesville, KY 42348
Ph 270.927.1000
Fax 270.927.1077

_____

Patients signature and date

**I understand that this authorization can be revoked by me at any time. I understand that revocation will not apply if the records have all been released. I understand that material released as a result of this authorization may be subject to redisclosure and no longer protected by the laws applying to medical information. This authorization will expire in 60 days unless otherwise indicted.

_____

Witness signature and date