Wise Health Clinics
Primary Care

133 N FM 730 # 105, Boyd, TX 76023

(940) 433-2151 (Phone)

940-433-2366 (Fax)

Last Name	First Name	Middle Initial

Date of Birth	SSN#	Driver's License #	Marital Status: M S D W

Mailing Address:	City:	State:	Zip:

Parent / Legal Guarding if patient is a Minor:

Home Number:	Cell Number:	Work Number:

Leave Voice Message? Yes☐ No☐	Leave Text Message? Yes ☐ No☐	Leave Texts and Voicemails In: Morning☐ Afternoon ☐ Evening☐	Language: English☐ Spanish ☐

Email Address:	Race: Asian☐ White ☐ Hispanic☐ Indian ☐ African American☐ Other☐

Occupation:	Employer's Name:	Are you a Veteran Yes☐ No☐

Employer's Address:	City:	State:	Zip:

Spouse's Name	Spouse's Employer

Emergency Contact Name:	Relationship:

Emergency Contacts Home #	Emergency Contacts Work #	Emergency Contacts Cell #

Pharmacy Name:	Pharmacy Phone:	Pharmacy Address:

Insurance Company:	Policy#	Group #:

Subscriber's Name:	Date of Birth:	SSN#:

Patient Medical / Social History

Medical History

Patient Name: **DOB:**

Previous Doctors:	
List any known **allergies** (Drug, Latex, etc.)	
Please Circle any Chronic Illness diagnoses you have: Diabetes Depression Arthritis High Blood Pressure Hep C	
Heart Disease Stroke Cancer Migraines Seizures Asthma	
What Medications Are You Currently Taking?	
Any exposure to toxic / dangerous substances at work? Yes☐ No☐ Please List:	
Please list any **herbal supplements or vitamins** you take	
List previous surgeries:	
Have you been hospitalized in the past 6 months Yes☐ No ☐	Have you had an emergency department visit in the last 6 months? Yes ☐ No☐
Are your immunizations up to date? Yes☐ No ☐	Have you ever had a blood transfusion? Yes☐ No☐
Are any other doctors treating you? Yes☐ No☐ If so Who?	
Do you have a living will or other Advance Directive? Yes☐ No☐ I Do not know what this is ☐	
Women: Are you pregnant, planning a pregnancy, or nursing a child? Yes☐ No☐	
How many pregnancies have you had?_____ Live Births? _____ Still Births/ Miscarriages? _____ How many vaginal births _____ How many cesarean births? _____	
How old were you when you started having periods?	Are your periods regular? Yes☐ No☐
What is your form of birth control?	Are you menopausal? Yes☐ No☐
When was your last mammogram?	Have you ever had an abnormal Pap Smear? Yes☐ No☐

Social History

Patient Name: **DOB:**

Do you Smoke? Yes☐ No ☐ **Do you smoke electronic cigarettes/e-ciggs? Yes☐ No☐** If yes how many/day? _____ If yes, how soon after waking up do you smoke (check one of the following) Within 5 Minutes ___ 6-30 minutes ___ 31-60 minutes ___ 60+ minutes ___
Do you drink alcohol? Yes☐ No☐ For how long? ___ How much? ____ Have you used recreational drugs? Yes☐ No☐ Describe type(s)
Do you have children? Yes☐ No☐
Do you follow a special diet? Yes☐ No☐ explain:

Family History

Place a check mark in box to indicate if family member has/had the disease	**Father** **Alive ☐** **Deceased☐**	**Mother** **Alive☐** **Deceased☐**	**Father's Parents** **Alive☐** **Deceased☐**	**Mother's Parent's** **Alive☐** **Deceased☐**	**Siblings**	**Children**
High Blood Pressure						
Diabetes						
Heart Disease						
Stroke						
Thyroid Disease						
Liver Disease						
Kidney Disease						
Cancer						
Asthma						
Allergies						

Patient Name: _____ **DOB:** _____ **SSN#:** _____

CONSENT FOR TREATMENT FORM

_____ (Initial)

I understand that I have presented myself to WISE HEALTH CLINICS for evaluation and/or treatment for my condition. I authorize and direct WISE HEALTH CLINICS to perform quality care upon me, and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

FACSIMILE AUTHORIZATION FORM

_____ (Initial)

I, the undersigned, authorize WISE HEALTH CLINICS to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed. I may revoke this authorization by giving WISE HEALTH CLINICS five (5) days written notice. **This revocation may be by facsimile transmission; however a written copy of the revocation must be mailed to WISE HEALTH CLINICS as well.**

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

_____ (Initial)

I hereby give authorization of insurance benefits to be made directly to **WISE CLINICAL CARE ASSOCIATES** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

ACKNOWLEDGEMENT OF PATIENT RIGHTS

_____ (Initial)

I have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. But any disclosures givien in reliance on this prior consent will be permissible.

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES

_____ (Initial)

I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the **Patient Responsibilities Notice** posted in all WISE HEALTH CLINICS locations. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ (Initial)

I acknowledge that WISE HEALTH CLINICS has provided me with the opportunity to view and read a written copy of their ***NOTICE OF PRIVACY PRACTICES.***

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_____ (Initial)

I acknowledge that Wise Clinical Care Associates will disclose my Protected Health Information (PHI) to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care.

People we can disclose your PHI to: **Relationship to self:**

_____ _____

OR

_____ (Initial) **I OBJECT** to the disclosure of my **Protected Health Information** to a family member, other relative, close friend or any other person.

_____ (Initial) **SHARING OF INFORMATION FOR PURPOSE OF PAYMENT:** I acknowledge that WISE HEALTH CLINICS will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_____ (Initial) I acknowledge that Wise Clinical Care Associates may communicate with me via US mail, e-mail, and land line home phone, through the patient portal, on a cell phone and through text messaging.

ALTERNATIVE COMMUNICATION AUTHORIZATION

_____ (Initial) I request for an alternative method of communication such as alternative address or work phone number.

Alternative Method: _____ DATE: _____

Patient Signature: _____

Personal Representative Signature: _____ Relationship to Patient: _____

(If applicable)

PCMH AGREEMENT CONSENT FORM

_____ (Initial) I have had an opportunity to read and review my own copy of **WISE HEALTH CLINICS's Patient Centered Medical Home Patient-Provider Agreement.** Furthermore I consent to be treated under this medical model which aims to benefit my health outcomes.

PRESCRIPTION POLICY CONSENT FORM

_____ (Initial) For non-narcotic prescription refills I will give the office at least 24 hour notice I also understand that if I do not sign the drug policy consent or refuse to submit for a drug test I could be dismissed from the practice. By initialing here I also agree to give WISE HEALTH CLINICS to look up past medicines prescribed to me by this provider and any others.

No Show- Missed Appointments

_____ (Initial) For any reason you need to cancel an appointment please notify our office as a soon as possible. On your second no-show occurrence, there will be a $25 charge to your patient account. After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

Wise Health Clinics

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty five dollar ($25) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3.*Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this is will not be covered by your insurance company.

4. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Patient Signature Patient/Guardian Date

Patient Account #_____

(Office Use Only)