HEALTH and WELLNESS

full Circle

PARTNERING WITH YOU FOR OPTIMAL HEALTH

Full Circle Health and Wellness

Family Practice

PATIENT INFORMATION

Patient Name:_____

Age:_____ DOB:_____ Sex:_____ Marital Status:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ County_____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Ethnicity/Race: (Circle)

White Hispanic African American Other: _____

Preferred Language: (Circle)

English Spanish Other: _____

Pharmacy Name: _____ City: _____

Primary Care Provider: _____ Phone: _____

Emergency Contact:_____ Phone:_____

Social History

Education	Marital Status	Exercise	Caffeine
☐ < 8th grade ☐ High School ☐ 2 yr. College ☐ 4 yr. College ☐ Post Graduate	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner	☐ No Exercise ☐ Occasional ☐ Moderate ☐ High Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # cups/cans per day?

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Alcohol	Tobacco	Drugs
Drink Alcohol? Yes No How Often? ☐ Occasionally ☐ <3 times/wk ☐ >3 times/wk # drinks/wk?_____	Do you use Tobacco? Yes No If not, did you ever use tobacco? ☐ Cigarettes___pks/day ☐ Chew____/day ☐ Cigars____/day # years used_____ Or years quit_____	Do you currently use recreational or street drugs? Yes No If yes, please list: _____ _____ _____ _____ _____

Health History Questionnaire

Allergies

Allergy	Reaction
1.	
2.	
3.	
4.	

Medications

Please be sure to include prescribed drugs, any over the counter drugs, vitamins and inhalers.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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Immunization History

Immunizations and most recent date

☐ Chickenpox Date:	☐ Meningococcus Date:
☐ Flu Shot Date:	☐ MMR Date:
☐ HPV Date:	☐ Pneumonia Date
☐ Hep A Date:	☐ Tdap Date
☐ Hep B Date	☐ Tetanus Date:
	☐ Zostavax (shingles) Date:

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last Pap Smear	Date:	☐ Abnormal	Check If Applies
Last Mammogram	Date:	☐ Abnormal	☐ Bleeding between periods
Age of First Menstrual Period			☐ Heavy Periods
Last Period/Age of Menopause (date/Age)			☐ Extreme Menstrual Pain
Number of Pregnancies:			☐ Vaginal Itching, burning, or discharge
Number of Miscarriages:			☐ Waking in the night to go to the bathroom
Number of Cesarean Sections:			☐ Hot Flashes
Number of Births:			☐ Breast Lump of nipple discharge
Number of Abortions:			☐ Painful Intercourse
Current sexual partner is: Male Female			☐ Sexually Active
Do you use condoms: Yes No			
Other Birth Control Method Used:			
Interested in being screened for STD's? Yes No			

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MEDICAL HISTORY

(Check all that apply)

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clot(s)	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV/AIDS	☐ Reflux or Ulcers
☐ Diabetes-Insulin	☐ High Cholesterol	☐ Stroke
☐ Diabetes-Non-Insulin	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other

Surgical History

Surgery	Reason	Year	Place
1.			
2.			
3.			
4.			
5.			

Full Circle Health and Wellness

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Family Health History

	Relation	Alive?	
Alcoholism	_____	Yes	No
Arthritis	_____	Yes	No
Cancer	_____	Yes	No
Diabetes	_____	Yes	No
Heart Disease	_____	Yes	No
Hypertension	_____	Yes	No
Depression	_____	Yes	No
Stroke	_____	Yes	No
Other:	_____	Yes	No

Additional Health Comments

Please feel free to add any health concerns or information about your health that you would like your provider to know.

_____ _____

Patient, guardian or caregiver signature Date

Full Circle

Health Assessment for Women

Name: Date:

Mail:

SYMPTOMS (Please Check Box)	Never	Mild	Moderate	Severe
1) Fatigue				
2) Mood Changes: Irritability Anxiety / Nervousness Depression				
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus				
4) Hot Flashes / Night Sweats				
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight				
6) Decreased Sex Drive: Vaginal Dryness				
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep				
8) Cold Hands & Feet / Always Cold				
9) Hair loss / Breakage				
10) Dry Wrinkled Skin				

FAMILY HISTORY (Please Check Box)	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

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Health Assessment for Men

Name: Date:

Mail:

SYMPTOMS (Please Check Box)

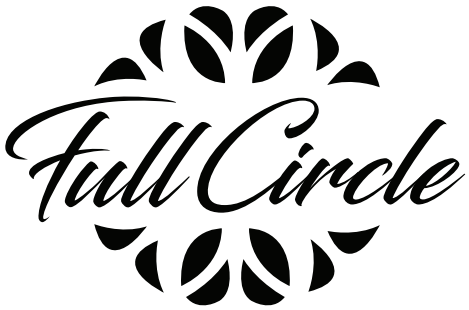
	Never	Mild	Moderate	Severe
1) Fatigue				
2) Mood Changes: Irritability Anxiety / Nervousness Depression				
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus				
4) Excessive Sweating				
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight				
6) Decreased Sex Drive: No Morning Erections				
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep				
8) Decreased Muscle Strength				
9) Hair loss / Breakage				
10) Joint Pain / Muscle Aches				

FAMILY HISTORY (Please Check Box)

	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Prostate Cancer		

Name: _____

DOB: _____



Insurance Information

Insurance company Name:

_____

Group #: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's SS #: _____

Subscriber's relationship to patient: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employers Phone #: _____

Secondary Coverage

Insurance company Name:

_____

Group #: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's SS #: _____

Subscriber's relationship to patient: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employers Phone #: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Statement of the Rights of Patients

1. Patients have the right to be treated with dignity and respect at all times.
2. Patients have the right to know of treatment options and degree of realistic outcomes of various options.
3. Patients have the right to know that being overweight or obese is a serious disease with known health risks.
4. Patients have the right to know that obesity is a chronic health disease, requiring personal effort over many years and probably involving lifelong changes in diet, exercise and behavior.
5. Patients have the right to know that rapid weight loss may cause serious health problems.
6. Patients have the right to know the anticipated cost and duration of services.
7. Patients have the right to know the provider's qualifications.
8. Patients have the right to privacy. The hospital, your doctor and others caring for you will protect your privacy as much as possible.
9. Patients have the right to know if this physician or healthcare facility has relationships with outside parties that may influence your treatment and care. These relationships may be with educational institutions, other health care facilities or providers.
10. Providers have a duty to maintain currency with obesity research and best practices appropriate to their specific profession.
11. Providers have a duty to determine each patient's medical and psychological condition prior to provision of services.
12. Providers have a duty to counsel each patient about realistic weight loss goals, the timelines to reach those goals and the diet, exercise and behavioral changes necessary to maintain weight loss and achieve associated health benefits.
13. Providers shall always provide for the best interests of the patient and will not recommend or provide products or services, which are not reasonably expected to be effective without informing the patient that they are participating in an experimental program and obtaining their informed consent.
14. Providers shall inform patients of this Bill of Rights.

Patient Name: _____ **Date:** _____

Patient Signature: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

Thank you for selecting our office for your medical care. We strongly feel that all patients deserve the very best medical care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our financial policy.

PLEASE READ AND SIGN THE FOLLOWING

1. I authorize this office to release or receive any information necessary to expedite insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for any charges deemed as non-covered by my insurance company. Such charges could be labs, vision tests, x-rays, hearing tests, after-hours surcharges, well child checkups and/or immunizations. I also understand that I am responsible for paying any co-pays, percentages and/or deductibles not covered by insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my full responsibility to pay my doctor's bill directly. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection proceedings; including court costs, filing fees as well as reasonable attorney's fees.

CONTRACTED INSURACE COVERAGE-HMO/PPO

If we are contracted with your insurance company, you will be expected to pay your co-pay at the time of service. These co-pays are usually on the office visit charge but some contracts have lab co-pay also.

NON-CONTRACTED INSURANCE COVERAGE

If you have medical coverage with an insurance company that we do not have an HMO or PPO contract with, your office visit charges are your responsibility and are due at the time of service. At a minimum, you will be expected to pay charges to the limit of any deductible not met on the date of service and/or any percentages your insurance company mandates as your responsibility.

ACCEPTED METHODS OF PAYMENT

We will accept payment of balances due by cash, money order, VISA, MasterCard, Discover and American Express.

OTHER INFORMATION

There will be a service charge on all returned checks. There will be an after-hours service charge for any patient treated in our office after 5:00pm or on Saturday or Sunday. Some insurance contracts will pay for this, but if it is deemed as a non-covered service you will be required to pay. Medicaid does deem this as a non-covered service and we ask that you pay the after-hours charge at the time of service.

AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION

The Patient/Responsible Party authorize(s) the release or receipt of and disclosure of any and all medical information related to the Patient's treatment and care, to or from any entity, which is, or may be liable, for Physicians charges, or to or from any Professional Review Organization associated therewith. The Patient/Responsible Party authorize(s) the release or receipt and disclosure of all or any part of Patient's medical records to or from any other health care provider who may be of assistance, in the opinion of the Clinician, in providing medical care and treatment for the patient, and/or assisting in any reimbursement or benefits to which patient may be entitled.

A photostatic copy of these authorizations and agreement shall be as valid as the original.

Signature:_____ Date:_____

Social Security #_____

NO-SHOW, LATE, & CANCELLATION POLICY

Description

"No-Show, No-Call" shall mean any patient who fails to arrive or call to cancel for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the office 10 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-show, no call and late cancellations. Full Circle Health & Wellness goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message **at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

1. A patient is notified of the appointment "No-Show, No-Call, Late & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.
2. **Established Patients:**
   a. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for future office visit, if available.
   b. Appointment must be canceled at least 24 hours prior to the scheduled appointment time.
   c. Patient will be charged $25 in the event that the patient has "No-Show, No-Call."
   d. In the event a patient has incurred (3) documented "no-show, No-Call" and/or "same-day cancellations," the patient may be subject to dismissal from Full Circle Health & Wellness. The patient's chart is reviewed, and dismissals are determined by Full Circle Health & Wellness review board, in accordance with Full Circle Health & Wellness system guidelines.

Print Patient Name | Patient Signature | Date

Full Circle Health and Wellness

Allen Ayers, FNP-C

RELEASE OF INFORMATION, AUTHORIZATION/CONSENT FORM

Client Name_____SSN_____DOB_____

I _____herby grant Full Circle Health and Wellness permission to release/receive the following information concerning my diagnosis and treatment to include specifically

__Medical Records
__Evaluations/Assessment
__Lab Results
__Progress Notes
__All
__Treatment Plan
__Social History
__School Records
__Radiology
__Discharge Summary
__HIV/AIDS
__Alcohol/Drug Treatment
__Other _____
_____
__Exchange information while my case remains active, NOT to exceed 1 year.

The above information is to be released/received with:
Name: _____
Address: _____
Phone/Fax _____
For the purpose of _____

This authorization is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance her on , and if not earlier revoked. It shall be terminated 90 days from the date signed without expressed revocation. Exception: Exchange of information is valid while case is active, but not to exceed 1 year.

Client Signature _____ Date _____
Guardian Signature _____ Date _____
Staff Signature _____ Date _____
If revocation is desired:
Client Signature _____ Date _____
Staff Signature _____ Date _____

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR PART 2) prohibit you from making any further disclose of it without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulations A general authorization for the release of medical or other information is not sufficient for this purpose.

1702 W Gilchrist Ave, Artesia, NM 88210 *Phone 575-513-7696 *Fax 866-516-1214