PATIENT REGISTRATION

DATE:_____ **Previous/Referring Physician:**_____

Patient Name:_____ **DOB:**_____

Marital Status: Single/ Married/ Divorced/ Widowed

Mailing Address:_____ **City/State:**_____ **ZIP:**_____

Home Phone:_____ **Cell Phone:**_____

Primary Insurance:_____ **Policy # :**_____

Group # :_____

Secondary Insurance :_____ **Policy # :**_____

Group # :_____

Emergency Contact Information

Personal Information will be shared with this person in the event of an emergency, or if you are incapable of coherent thought.

Name:_____

Relationship to patient:_____

Home/Cell number:_____

I understand that all services are on a cash basis unless the physician participates with my insurance or other arrangements have been made with the financial department prior to my appointment.

ALL CO-PAYS ARE DUE AT TIME OF SERVICE

Patient/ Guarantor Signature:_____

NEW PATIENT HISTORY

DATE:_____

Patient Name:_____ **Gender: Male/ Female/ Other**
Date of birth:_____ **Age:**_____
Pharmacy:_____ **Phone #:**_____

Chief Complaint

What is the main reason for your visit today? :_____

_____

Medication *If you need more room use the back of this sheet

Surgery

Surgery	Year

Allergies - medications/food/environment

Review of Systems Checklist

Please put a check mark by any symptoms that you have had recently. Please check "none" if you have not noticed any of the symptoms listed in that category.

Cardiovascular:

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Swelling of the feet
- ❑ Racing Pulse
- ❑ Irregular heart beat
- ❑ Is your blood pressure under control?
  - o Yes
  - o No
  - o Unsure
- ❑ None

Constitutional:

- ❑ Fever
- ❑ Weight loss
- ❑ Fatigue
- ❑ Loss of Appetite
- ❑ Chills
- ❑ Night Sweats
- ❑ Poor appetite
- ❑ None

Endocrine:

- ❑ Excess thirst
- ❑ Excessive urination
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Hair loss
- ❑ Dry skin
- ❑ Is your blood sugar under control?
  - o Yes
  - o No
  - o Unsure
- ❑ None

Gastrointestinal:

- ❑ Abdominal pain
- ❑ Nausea
- ❑ Diarrhea
- ❑ Bloody stools
- ❑ Stomach Ulcers
- ☑ Constipation
- ❑ Trouble Swallowing
- ❑ Jaundice/yellow skin
- ❑ None

Genitourinary:

- ❑ Genital sores or ulcers
- ❑ Kidney Failure/Problems
- ❑ Kidney stones
- ❑ Painful/difficult urination (Prostatitis)
- ❑ Testicular pain
- ❑ Urinary discharge
- ☑ None

Hematology/Oncology:

- ❑ Easy bruising
- ❑ Prolonged bleeding
- ☑ None

HENT:

- ❑ Hearing loss
- ❑ Sore throat
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Jaw Claudication (pain in jaw when chewing)
- ❑ Ear ache
- ❑ None

Integumentary:

- ❑ Rash
- ❑ Change in mole
- ❑ Skin sores
- ❑ Skin cancer
- ❑ Sever itching
- ❑ Loss of hair
- ❑ None

Musculoskeletal:

- ❑ Muscle aches
- ❑ Joint pain
- ❑ Difficulty laying flat due to muscle pain
- ☑ Back pain
- ❑ None

Neurologic:

- ❑ Weakness
- ☑ Headaches
- ❑ Scalp tenderness
- ❑ Dizziness
- ❑ Paralysis of extremities
- ❑ Tremor
- ❑ Stroke
- ❑ Numbness or tingling
- ❑ Seizures or convulsions
- ❑ Fainting
- ❑ None

Respiratory:

- ❑ Wheezing
- ❑ Cough
- ❑ Coughing up blood
- ❑ Severe or Frequent colds
- ❑ Difficulty breathing
- ❑ None

Name: _____ **Date of Birth:** _____ **Date Completed:** _____

Requesting Records from: _____

_____

Authorization to use or disclose my health information

Patient Name: **Date of Birth:**

I. **My Authorization**

You may use or disclose the following health care information (check all that apply):

- ☐ Include or Exclude: My health information related to drug abuse.
- ☐ Include or Exclude: My health information related to alcohol abuse.
- ☐ Include or Exclude: My health information related to HIV/AIDS.
- ☐ Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes.

My health information related to the following treatment or condition: _____

My health information for the dates(s): _____

You may disclose this information to: Leslie Nelson FNP, Elizabeth Fanning FNP, & Dana Guilkey FNP

Name (title) & Organization: Canon Professional Wellness Clinic, 730 Macon Ave Canon City CO 81212

Fax: 719-275-7334 Phone: (719)275-1618 *Do not send records on disc. Fax, Email Only*

Reason(s) for this authorization (check all that apply):

- ☐ **At my request**
- ☐ **Other (specify):** _____

LI. **My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment). However, I do not have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-name practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Revoke ti by writing a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature:_____

Date_____

Canon Professional Wellness Clinic

730 Macon Ave Canon City CO 81212

Phone:719-275-1618 Fax:719-275-7334

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. CONSENT FOR TREATMENT. I voluntarily consent to inpatient and/or outpatient care and treatment performed by my provider. I also consent to routine hospital services, diagnostic procedures, medical treatment, and other services and hospital care as deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have the right to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider.
2. AUTHORIZATION FOR RELEASE OF INFORMATION. I authorize Canon Professional Wellness Clinic LLC to utilize confidential medical/surgical or other information contained in my medical record as necessary for claims payment, medical management or quality of care review purposes. I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an acquired immunodeficiency syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time but only with respect to the proposed treatment and not with respect of care and treatment that has already been rendered to me.
3. MEDICARE, MEDICAID, OR COLORADO INDIGENT CARE PROGRAM. I authorize and holder of medical or other information about me to release to Social Security Administration, the Department of Health and Human Services, the Colorado Department of Social Services and their intermediaries, carriers or agents any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf.

4. PAYMENT AGREEMENT AND ASSIGNMENT. Except as prohibited by any agreement between my insurance company and Canon Professional Wellness Clinic LLC or by state or federal law, I AGREE TO BE RESPONSIBLE FOR MY CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES AND OTHER CHARGES FOR MEDICAL SERVICES NOT COVERED OR PAID BY INSURANCE OR OTHER THIRD PARTY PAYERS. I authorize Canon Professional Wellness Clinic LLC to file claims for payment of any portion of the patient bills and assign all rights and benefits to Canon Professional Wellness Clinic LLC as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event Canon Professional Wellness Clinic LLC has to take action to collect same because of my failure to pay in full all incurred charges. 5. EXPRESS CONSENT TO COMMUNICATE. I hereby authorize this provider and its employees, agents and assignees to contact me via email and text messaging, and to my cellular devices. I consent to Canon Professional Wellness Clinic LLC and its assignees to communicate with me, by telephone, email, fax, or other means. I HAVE READ THIS FORM AND BY SIGNING THIS FORM, I UNDERSTAND AND AGREE TO ITS TERMS

_____ _____/_____/_____

Patient Signature (Or Parent/Guardian/Other authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form

Date

_____ _____/_____/_____

Print name and relationship of person authorized to sign for patient

Date

Canon Professional Wellness Clinic

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Office Policies

When cancelling appointments, you must call in and give 24 hours' notice in order for us to be able to fill that appointment slot or you will be charged a $25.00 cancellation fee.

If you **NO SHOW** an appointment you will be charged a $25.00 no show fee. Consequences of "No Show" appointments. After 3 No shows you will be dismissed from the practice. Patient dismissal is at the discretion of your medical provider. If you are dismissed from the practice your remaining appointments will be cancelled. Only emergency medical treatment will be offered within the first 30 days of dismissal.

CO-PAYS and balances are due at the time of appointment, or your appointment will be rescheduled. **SELF-PAY PATIENTS-** payment is due at the time of service.

If you are **5** minutes late for your appointment your appointment may be rescheduled. As, at this point you have run into another scheduled patient's appointment time. Our schedules cannot accommodate anyone arriving past their scheduled time.

Insurance cards and photo ID are required at each appointment.

Please be aware that there is more than one Practitioner in this office. Patients will be arriving at different times and be seen by appointment time, not arrival time depending on which Practitioner they are seeing. If your Practitioner is running behind you are more than welcome to wait or if you would like to reschedule, we would be happy to do that for you. We thank you for your cooperation.

Signature: _____

Date: _____/_____/_____