RESET FORM

14855 Blanco Rd, Suite 400
San Antonio, TX 78216

Wellness Institute of Texas
Live Well. Look Well. Be Well

PHONE 210-802-1133
FAX 210-493-2900

NEW PATIENT FORM - CHILD

Please fill out the form using **Adobe Reader**. Print this form, sign/print blanks that require your signature and printed name.

PATIENT DEMOGRAPHICS

FIRST NAME | MIDDLE | LAST NAME

DATE OF BIRTH | GENDER | SOCIAL SECURITY NUMBER | MARITAL STATUS

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME NUMBER | CELL NUMBER | WORK NUMBER | EMAIL

EMPLOYER

EMPLOYER | EMPLOYER OCCUPATION

EMERGENCY CONTACT

NAME RELATION | HOME NUMBER | CELL NUMBER | WORK NUMBER

SPOUSE / PARENT / LEGAL GUARDIAN DETAILS

NAME RELATION | HOME NUMBER | CELL NUMBER | WORK NUMBER

SOCIAL SECURITY NUMBER | DATE OF BIRTH

OTHER INFORMATION

LANGUAGE | RACE | ETHNICITY | RELIGION

INSURANCE INFORMATION

Responsible Party (Primary Card Holder) Information

NAME OF PRIMARY INSURANCE COMPANY

LAST NAME, FIRST NAME, MIDDLE | DATE OF BIRTH | GENDER | SOCIAL SECURITY NUMBER | MARITAL STATUS

ADDRESS (if different from patient)

OTHER DOCTORS List other medical providers your child is currently seeing

PROVIDER NAME | SPECIALTY | ADDRESS | PHONE NUMBER

PROVIDER NAME | SPECIALTY | ADDRESS | PHONE NUMBER

How did you hear about us? Who referred you to us? _____

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LEGAL RESPONSIBILITY FORM

The date, extent or condition upon which this authorization expires is not to exceed 24 months (except for research purposes, state "none" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise stated or revoked, this authorization will expire in ninety (90) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I understand that provider's records may contain information created by an entity other than **Wellness Institute of Texas** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records).

I expressly request release of all records maintained by **Wellness Institute of Texas** concerning me or my child, including incorporated records.

I acknowledge that **Wellness Institute of Texas** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Wellness Institute of Texas** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Wellness Institute of Texas** is not responsible for completeness, legality, or omissions caused by the copying of any medical records from another institution.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ **DATE** _____

PRINT PATIENT'S NAME _____ **PRINT NAME OF PATIENT OR LEGAL GUARDIAN, IF APPLICABLE** _____

LEGAL GUARDIAN DECLINES AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

DATE: _____ **INITIALS**: _____

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OFFICE POLICIES

1. **CANCELLATIONS**: We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the **$50 NO-SHOW FEE**.

2. **TARDINESS**: If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots.

3. **PRESCRIPTION REFILLS**: Refill requests must be made at least one week in advance and should be faxed from your pharmacy to our office (210-493-2900) or requested through our online patient portal at www.wiotx.com. This reduces medication errors from phone messages.

4. **NARCOTICS / CONTROLLED SUBSTANCES**: Narcotics are carefully regulated medications and are generally not prescribed unless absolutely necessary. The providers at the **Wellness Institute of Texas** not only limit the use of narcotic prescriptions, but also want the patients who are prescribed narcotics to understand that if a patient reports the prescription was lost, a replacement prescription will not be issued. A limited number of narcotic medications will be prescribed. When the narcotic course is completed, the patient will be required to schedule an office visit and be seen by the provider. Narcotics refills will not be authorized without an office visit. Patients should be very careful with the prescription, treating it as one would cash.

5. **AFTER HOUR CALLS**: After-hours calls will be answered by our automated service. In case of an urgent matter that cannot wait for the next business day, you may reach the on-call provider. We will not call in new prescriptions or refill prescriptions after hours. Please make prescription refills and appointment requests during office hours or through our on-line portal at www.wiotx.com. See #3 above.

6. **MEDICAL RECORDS**: There is a $25.00 fee for release of medical records. This must be paid prior to the release of records as it helps cover the cost of printing and shipping. Please allow one week to process your request.

7. **COMPLETION OF FORMS**: As per the rules adopted by the State Board of Medical Examiners, our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days. Fees for forms are as follows: FMLA $50.00, HANDICAP Placard $25.00, DISABILITY $25.00, FOODSTAMP Forms $25.00.

8. **COLLECTION AGENCY FEES**: In the event that your account is turned for collection to a collection agency, you will be responsible for the collection agency fees.

I have read and understand the policies set by Wellness Institute of Texas and agree to the terms.

_____ _____

SIGNATURE **DATE**

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NAME _____ DATE OF BIRTH _____

PHARMACY _____ NUMBER _____

Is your child allergic to any medications? If yes, please list:

_____

_____

Do your child take medications? Please include regular use of over-the-counter medications, vitamins, and herbal supplements.

NAME:	STRENGTH:	INSTRUCTIONS:

Does your child have any of the following medical problems or have been diagnosed with any in the past?

- ____ Arrhythmia/Irregular Heartbeat
- ____ Urinary Incontinence
- ____ Congestive Heart Failure
- ____ Recurrent Bladder infections
- ____ Pneumonia
- ____ Meningitis
- ____ Erectile Dysfunction
- ____ Diabetes
- ____ Gallstones
- ____ ADD/ADHD
- ____ GERD/Heartburn
- ____ Heart Murmur/Valvular Disease
- ____ Osteoarthritis
- ____ Osteoporosis
- ____ Hepatitis
- ____ Anemia
- ____ Hyperlipidemia/High Cholesterol
- ____ Hypertension
- ____ Hypothyroidism
- ____ Seizure Disorder
- ____ Irritable Bowel
- ____ Allergies
- ____ Kidney Stones
- ____ Blood Clot (DVT/ pulmonary embolism)
- ____ Fracture location: _____
- ____ Carotid Artery Stenosis
- ____ COPD/Emphysema/chronic bronchitis
- ____ Coronary Artery disease/Heart Attack
- ____ Chronic pain/Fibromyalgia
- ____ Crohn's/Ulcerative Colitis
- ____ Pancreatitis
- ____ Eczema
- ____ Peptic Ulcer
- ____ Cancer Type: _____
- ____ Peripheral Vascular Disease (PAD)
- ____ Gout
- ____ Renal Failure
- ____ Enlarged BPH
- ____ Rheumatoid Arthritis/ Lupus
- ____ Asthma
- ____ Sleep Apnea
- ____ Alzheimer's/Dementia
- ____ Stroke/TIA
- ____ Headaches/Migraines

MALES: Please proceed to the next page →

ADOLESCENT GIRLS ONLY *Please fill out what is applicable.*

Age at First Period: _____ Date of last menstrual cycle: _____

Any problems with your child's menstrual cycle? _____

Any Pregnancies? _____

Are you using birth control? Yes No If yes, what? _____

Date of last Pap smear: _____ Results: _____

Any abnormal Pap? Yes __ No If yes, please explain: _____

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Has your child been hospitalized? If so, please give dates and reasons.

Has your child had any surgeries? If so, please list with dates.

Please list medical problems in your family and indicate if living or deceased. If none or unknown, please list as well.

Father: _____

Mother: _____

Brother(s): (number of): _____

Sister(s): (number of): _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

BIRTH HISTORY

Was your child born on time? Yes No If not, how many weeks early? _____

What type of delivery? _____ Any complications? _____

Did your child require hospitalization or care after birth? If so, explain _____

To the best of your knowledge, is your child up to date on vaccines? If not, please list known deficiencies.

_____

(Please supply us a vaccination record if possible)

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PLEASE GIVE US INFORMATION ABOUT YOUR CHILD'S ENVIRONMENT

Grade in school: _____ School performance: _____

Sports: _____

Household members: _____

Number of siblings: _____ Parents marital status: _____

Is your child exposed to cigarette smoke? Yes No If so, who? _____

Does your child use tobacco products? Yes No

If so what type? Yes No How much daily/week? _____

When did you start? _____ For prior use, when did you quit? _____

For how long? _____

Does your child drink alcohol? Yes No If so, how often? _____ Amount? _____

If prior use, when did you quit? _____ Years of use? _____

Has your child ever used any illegal or illicit drugs? Yes No

If so, please give type: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for **Wellness Institute of Texas** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Wellness Institute of Texas** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Wellness institute of Texas** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wellness Institute of Texas, Attn Rochele Nicolas-Wedige, 14855 Blanco Rd, suite 400, San Antonio, TX 78216.

With this consent, **Wellness Institute of Texas** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Wellness Institute of Texas** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **Wellness Institute of Texas** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Wellness Institute of Texas** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Wellness Institute of Texas** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Wellness Institute of Texas** may decline to provide treatment to me.

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____ _____
PRINT PATIENT’S NAME **DATE**

_____
PRINT NAME OF PATIENT OR LEGAL GUARDIAN, IF APPLICABLE

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DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of that a communication of PHI be made my alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Please put a check mark to indicate how you wish to be contacted about lab results or other PHI:

HOME: O.K. to leave messages with detailed information ____ Leave message with call-back number only ____

O.K. to mail to my home address ____ O.K. to fax to this number: _____

WORK: O.K. to leave messages with detailed information ____ Leave message with call-back number only ____

CELL: O.K. to leave messages with detailed information ____ Leave message with call-back number only ____

People I authorize *Wellness Institute of Texas* to share my child's PHI with:

_____ _____
PRINT FULL NAME **RELATIONSHIP**

_____ _____
PRINT FULL NAME **RELATIONSHIP**

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INFORMATION ON PREVENTATIVE CARE VISITS

Due to insurance regulations, all physicals, well-woman exams and well-child exams are considered preventative care visits. Most insurance companies cover 100% of one preventive care visit per year.

The visits cover general check-ups, routine cancer screenings, immunization and counseling on diet and exercise, child development and vitamin supplements. Unfortunately, insurance companies will not cover non-preventative care issues raised during a preventative care visit. As such, we strongly encourage you to make a separate, follow-up appointment with our doctors if you have medical concerns that fall outside of preventative care. This will prevent your insurance company from billing you extra for your preventative care visit while ensuring our doctors schedule the appropriate amount of time to address your medical concerns. We thank you for your understanding in this matter.

_____
PRINT NAME

_____
SIGNATURE

_____
DATE OF BIRTH

_____
DATE

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY _____

By signing this authorization, I hereby authorize _____

To release health information including copies of my medical records to the following person(s) or facilities at the locations listed for the purpose described:

Wellness Institute of Texas
14855 Blanco Rd # 400 San Antonio, TX 78216
Phone: (210) 802-1133
Fax: (210) 493-2900

___ At the Request of the Individual / Patient
___ Continuum of Medical Care
___ Insurance:
___ School
___ Legal Matter
___ Other (*please specify*): _____

INFORMATION TO BE RELEASED

___ ENTIRE RECORD
___ Physician Notes
___ Radiology Report
___ Billing
___ Immunization record
___ Lab Results
___ Operative Report
___ Alcohol/Substance Abuse
___ HIV Record
___ STD Record
___ Psych/Mental Health
___ Other: _____

- I understand that I have a right to revoke this authorization at any time. *
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.
- I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.
- I understand that signing this authorization does not cancel any rights I have under the other state and federal laws.
- I understand that you will provide information within 10-14 days from the receipt of the request.

Form must be completed before signing

SIGNATURE OF INDIVIDUAL OR REPRESENTATIVE _____ DATE _____