WELCOME

Date:_____

Trinity WELLNESS Center
Patient Information

Name: _____
Last First MI

Mailing Address: _____

_____

Phone # (H)_____ (W) _____ (Cell) _____

Can we call you at work? ❑ Yes ❑ No EMAIL:_____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) & PHOTO ID

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? (doctor and/or practice) _____ Phone _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any allergies (meds, foods, seasonal): _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

APPOINTMENT CANCELLATIONS
AND
CONSENT TO TREAT

We now require a 24-hour notice for cancelled appointments. If appointments are not cancelled by the notice required, there will be a fee of $30, which must be paid before your next office visit.

This change will allow us to offer open appointment times to other patients who may need them.

We appreciate any help you can give us in this matter. We appreciate your business.

By signing below, I am stating that I understand and agree to the aforementioned statements and terms.

CONSENT TO TREAT

I hereby authorize the Doctors at **Trinity Wellness Center, LLC.** to treat my case as they deem appropriate through the use of medical care, physical therapy, rehabilitation, manual therapy, chiropractic adjustments of the spine and extremities, nutritional support, trigger point injections, large joint injections and diagnostic testing. I realize the goal of holistic healthcare is to naturally strengthen the patient's body in order for the body to better heal itself and not to treat a particular condition or disease. I also realize this office offers alternatives to holistic care in the form of traditional medical care and that I may elect to receive those services as well. This office will not assume responsibility of treatment of any particular conditions or disease.

It is understood and agreed the amount paid to the clinic for x-rays is for cost of materials and interpretation and the x-ray originals will remain the property of this office for a period of 10 (ten) years, pursuant to Georgia law. The patient will be entitled to a written report of x-ray findings. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____ _____

Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

Signature below is only acknowledgement that you received the HIPAA Notice of our Privacy Practices:

Print Name: _____

Signature: _____ **Date:** _____

PERMISSION TO LEAVE A MESSAGE

By signing below, I am giving Trinity Wellness Center permission to leave appointment reminders on my home/cell answering machine/voicemail. If a live person answers the phone, Trinity Wellness Center has my permission to leave a message with the person answering the phone.

_____ _____

Patient Signature Date

PERMISSION TO SHARE HEALTH INFORMATION

By signing below, I am authorizing Trinity Wellness Center to discuss my health information with the following persons, if necessary. This authorization will remain in effect unless I revoke permission in writing.

Persons authorized to receive health information:

1. _____ _____
   Print Name Relationship to Patient Phone Number

2. _____ _____ _____
   Print Name Relationship to Patient Phone Number

3. _____ _____ _____
   Print Name Relationship to Patient Phone Number

_____ _____

Patient Signature Date

NO SIGNATURE REQUIRED IF PERMISSION TO SHARE HEALTH INFORMATION IS LEFT BLANK

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnosis or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a diagnostic testing, may require that your relevant protected health information be disclosed to the health plan to obtain approval for the testing

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceeding, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS ARE EXPLAINED BELOW:

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information *(FEES MAY APPLY)* – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information complied in reasonable anticipation of or used in, a civil, criminal, or administrative action or proceedings, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information –This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Your have the right to receive an accounting of certain disclosures- You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer. **We will not retaliate against you for filling a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.