Patient Registration Information

Please print and complete all sections below

Patient's Personal Information: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Race: American Indian-Alaska Native-Asian-Black/African American-Native Hawaiian-White-Pacific Islander-More than one race-Refuse to report
Ethnicity: Hispanic or Latino---Not Hispanic or Latino---Refuse to report/unreported
Preferred Language: English---Spanish---Other

Name: _____

Last Name First Name M. Initial

Date of Birth _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

Driver's License # _____ State issued: _____ Email Address: _____

Guarantor of Account Relationship to Patient: ☐ Self ☐ Spouse ☐Child ☐ Parent ☐ Other _____

Name: _____Date of Birth _____/_____/_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Employment Information: ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Employer: _____ Occupation: _____

Work Phone: (_____)_____ Address: _____

Insurance Information: Please present insurance cards to receptionist.

Primary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Secondary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

How were you referred to Harmony Clinics? Television_____ Social Media/Facebook/Twitter_____

Family/Friend_____ Word of Mouth_____ Walk-In_____ Other, Please Explain_____

Emergency Contact:

Name: _____ Relationship: _____

Address:_____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Harmony Clinics, and any assisting physicians for services needed. 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 collections, and reasonable attorney's fees. 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.

_____ _____

Signature Date

Harmony Clinics

HIPAA AUTHORIZATION

I, _____, give permission to Harmony Integratice Medicine Clinics, PLLC to:

☐ Use the following protected health information, and/ or

☐ Disclose the following protected health information to:

Names of entity or person to receive information:

_____

_____

_____

Information to be disclosed (check all that apply):

☐ Medical Records

☐ Treatment Records

☐ Diagnositic Records

☐ Other _____

This protected health information is being used or disclosed for the following purposes:

_____

_____

_____

This authorization expires on _____/_____/_____ or in 2 years if not specified otherwise.

If the person or entity receiving this information is not a health care provider nor a health plan covered by federal privacy regulation, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment of your elilgibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending a written notification to Harmony Integrative Medicine Clinics, PLLC at 4412 Kell Blvd., Wichita Falls, Texas 76309. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorizaton.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

FINANCIAL POLICY

Thank you for choosing Harmony Clinics for your healthcare needs. This policy was created to outline our expectations of you regarding your financial responsibilities to this clinic.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

As a patient of Harmony Clinics, you will be required to sign a financial responsibility form. Payment is required at the time services are rendered unless other arrangements have been made in advance. Patients with an outstanding balance must make arrangements prior to scheduling appointments. **Any two consecutive months without payment or contact with the billing department will cause the remaining balance to be turned over to collections. Accounts that have been turned to an outside collection agency MUST be paid in full prior to scheduling appointments, including any labs, and/or being seen in our walk-in clinic.**

INSURANCE

We bill participating insurance companies as a courtesy service to you. You are expected to pay your **deductible and co-payments or coinsurance** at the time of service. On occasion, your insurance may determine that the services you received are not covered. **Please read your insurance handbook and be aware of services that are considered non-covered**. When in doubt, contact your insurance company directly for clarification. You will be responsible for services not covered by your insurance plan. If we do not receive payment from your insurance company within 90 days of the claim filing date, patients will be expected to pay the balance in full.

SELF-PAY PATIENTS

Self-Pay patients and patients who present without proof of insurance for verification are required to pay for services in full at the time services are rendered. Also, a $75.00 deposit is required at the time of check-in. We understand that affordable insurance coverage is not readily available for all of our patients. We also realize the lack of insurance coverage may determine the level of care that individuals seek for themselves or their families. Bearing that in mind, our Self-Pay policy includes discounted rates for our services. Any charges not paid on the date services are rendered will NOT receive the Self-Pay discount. **PLEASE NOTE YOUR BALANCE TODAY IS AN <u>ESTIMATE</u> OF YOUR CHARGES. YOU MAY STILL RECEIVE A BILL FOR SERVICES RENDERED.**

FORMS OF PAYMENT

We accept Cash, Checks, Visa, MasterCard, Discover, and American Express.

RETURNED CHECKS

All returned checks are handled through Check Net. Any returned check must be taken care of prior to scheduling an appointment. In the event of a second returned check, this method of payment will no longer be accepted.

I have read and understand the Harmony Clinics' Financial Policy.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Notification Regarding Radiology and Laboratory Services

Please be advised that if you receive any technical services such as x-rays and pathology, you will be billed the professional services by other providers as well. For example, your pathologist and radiologist **(those who interpret lab and x-rays)** bill separately from our clinic and may not participate in the same health plans as Harmony Clinics. You will be responsible for paying these providers subject to the terms of your health plan or insurance, if any. Additionally, Clinical Pathology Laboratories, INC., which is an outside laboratory, will bill for all lab services. If you have questions regarding these bills, please call the billing number located on the statement you received.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Consent to Text or Email for Reminders and Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind them of an appointment, to obtain feedback on their experience with our healthcare team, and to provide general health reminders/information. By signing below, you consent to receiving appointment reminders and other healthcare communications/information at the email or text address listed.

_____(patient initials) I consent to receive text messages from the practice on my cell phone, as well as any number forwarded or transferred to that number, or emails that include communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number I authorize to receive text messages is: _____
The e-mail address I authorize to receive email messages is: _____

The practice does not charge for this service, but standard text messaging rates may apply according to your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my authorization for future communications via e-mail and/or text.

_____I hereby revoke my authorization to receive any future appointment reminders, feedback, and general health via text messages.

_____I hereby revoke my authorization to receive any future appointment reminders, feedback, and general health via e-mail.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Medical History

Name:_____ DOB:____/____/_____ Date:____/____/_____

Do you have any of these medical problems? If **YES** please circle.

Eyes - cataracts, glaucoma, glasses/contacts, macular degeneration, other_____
Ear, Nose & Throat - allergies, sinusitis, dental abscess, swollen glands, chronic sore throat, TMJ
Heart - high blood pressure, irregular heart beat, heart failure, heart attack, CAD
Lungs - asthma, emphysema, COPD, pneumonia, sleep apnea, cancer
Stomach & Intestines- reflux, ulcers, irritable bowel, diverticulosis, constipation, cancer
Urinary - urine incontinence, prostate disease, sexually transmitted disease, kidney stones
Muscles & Joints - arthritis, pain in arms/legs/neck/back, radiating pain
Brain & Nerves - seizures, headache, migraines, stroke, Parkinsonism, dementia
Skin - acne, eczema, psoriasis, hives, cancer, other _____
Hormones - diabetes, thyroid, high cholesterol, menopausal, osteoporosis, gout
Blood - anemia, bleeding, blood clots, cancer
Psychiatric - depression, anxiety, bipolar, schizophrenia, other _____

Have you had any surgeries? If **YES** please circle and note **WHEN (dd/mm/yy)** or **AGE**.
Tonsils, Appendix, Gallbladder, Uterus, Ovaries, Heart, Colon, Hip, Knee, Prostate, Breast, Back, Other

Please list other physicians who provide care for you._____

Are you currently taking any medicines? If **YES** please write them below, or provide a current list

Name of Medicine	Medicine Dose	How many times each day?	For what condition?

Are you allergic to any medications? If **YES** please write them below.
1._____ 2. _____ 3. _____
4._____ 5. _____ 6._____

Family's Medical History

Father Living or Deceased Age_____Medical problems_____
Mother Living or Deceased Age_____Medical problems_____
Sibling 1 (B/S) Living or Deceased Age_____Medical problems_____
Sibling 2 (B/S) Living or Deceased Age_____Medical problems_____
Sibling 3 (B/S) Living or Deceased Age_____Medical problems_____

Social History Information

Are you adopted? (Y/N) Employed or Retired? Occupation_____
Married (Y/N) Widowed (Y/N) Divorced (Y/N)_____ Do you have children? (Y/N) _____
Do you Smoke? (Y/N) Did you use to smoke? (Y/N) How many packs? _____
How Long? _____ Quit? (Y/N) When? _____ Smokeless Tobacco (Y/N)
Do you drink alcohol? (Y/N) Did you use to drink alcohol? (Y/N) What kind? _____
How Often? _____ Quit? (Y/N) When? _____ Attend AA? (Y/N)
Substance Abuse? (Y/N) What? _____ When? _____ How Long? _____ Quit? (Y/N)

Office Use Only
Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____

Medical History (Cont.)

Name:_____ DOB:____/____/_____ Date:____/____/_____

Please circle each symptom you have experienced in the past thirty (30) days.

General	weight loss, weight gain, fatigue
Eye	blind spots, double vision, pain with sun light, red eyes
Ear, Nose & Throat	hearing loss, ringing, dizziness, pain, runny nose, nose bleeds, sinus drainage, difficult or painful swallowing, hoarseness, mouth sores, bleeding gums, allergies
Heart	chest pain, pounding heart, racing heart, shortness of breath, difficulty breathing, swelling, blue fingers or lips
Lungs	wheezing, difficulty breathing, cough, night sweats, short of breath, pneumonia, bronchitis
Stomach & Intestines	pain, nausea, vomiting, diarrhea, constipation, heartburn, bloody/black stool, hemorrhoids, change in bowel movements
Urine	painful urination, frequent urination, bloody urine, leaking urine, cloudy urine, waking up to urinate Male: hernia, difficulty with erection, penile discharge Female: vaginal discharge, painful intercourse
Muscles & Joints	pain, numbness, tingling, weakness, clumsiness, swelling
Brain & Nerves	headache, fainting, shaking, tremor, clumsiness, dizziness, numbness, tingling, falling, memory loss
Hormones	eating a lot, drinking liquids a lot, tremor, night sweats,
Blood	easy bruising, easy bleeding, nodes/glands enlarged, varicose veins
Skin	rashes, lesions, moles, finger/toe nail problems
Psychiatric	sadness, stress, guilt, depression, anxiety, crying, nerves, suicidal thoughts, appetite changes, agitation
Other	anything else not listed above _____

Women Only--Please answer the following questions:

Last menstrual period _____
Age when periods started _____
Number of Pregnancies _____
Are you currently pregnant? _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Age at Menopause _____
Menstrual Period: Regular or Irregular Light / Moderate / Heavy
_____# days bleeding every _____ days

Office Use Only

Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____