RELIANCE
Health & Wellness Solutions, LLC

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P A T I E N T R E G I S T R A T I O N

Name: _____

Date of birth: _____ **Social Security #:** _____

Address: _____

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

Email: _____ **Occupation:** _____ **Employer:** _____

Marital Status: ***(circle one)*** Single Married Widowed Divorced
Race: ***(circle one)*** White American Indian/Alaska Native Asian African American Pacific Islander
Ethnicity: ***(circle one)*** Not Hispanic or Latino Hispanic or Latino
Preferred Language: ***(circle one)*** English Spanish Filipino

Emergency Contact: _____ **Relation:** _____

Phone: _____ **Address:** _____

PRIMARY INSURANCE
Insured Name: _____ **Social Security #:** _____ **DOB:** _____

Insurance Carrier: _____ **Phone:** _____

Policy Number: _____ **Group Number:** _____

SECONDARY INSURANCE
Insured Name: _____ **Social Security #:** _____ **DOB:** _____

Insurance Carrier: _____ **Phone:** _____

Policy Number: _____ **Group Number:** _____

PHARMACY
Pharmacy Name: _____

Address: _____ **Phone:** _____

RELIANCE Health & Wellness Solutions, LLC

Your partners in sickness & health

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Medical History: *(Please check if you've had any of the following)*

__ Alcoholism	__ Blood Transfusion	__ Heart Problems	__ Osteoporosis
__ Allergies	__ Cancer	__ Hepatitis A, B, C	__ Pneumonia
__ Anemia	__ Diabetes	__ High Blood Pressure	__ Polio
__ Anxiety	__ Depression	__ High Cholesterol	__ Rheumatic Fever
__ Asthma	__ Ear Problems	__ Joint Disorder	__ Stroke
__ AIDS/HIV	__ Eating Disorder	__ Kidney Disorder	__ Skin Disorders
__ Arthritis	__ Epilepsy	__ Liver Disorder	__ Stomach Ulcer
__ Back Problems	__ Glaucoma	__ Lung Disease	__ Substance Abuse
__ Bleeding Disorder	__ Gout	__ Measles	__ Thyroid Disorder
__ Blood Disorder	__ Heart Disease	__ Migraines	__ Tuberculosis

Please list any additional medical problems not listed above:_____

_____

Surgical History

Year	Surgery	Hospital

Family Medical History *(circle one)*

Mother: Living or Deceased? Age ____ If deceased; cause of death? _____

Father: Living or Deceased? Age ____ If deceased; cause of death? _____

If living, please list any health conditions: _____

_____

Social History

Do you exercise? YES / NO — If Yes, how many minutes a day?_____

Are you Dieting? YES / NO — If Yes, are you on a physician prescribed medical diet?_____

Number of meals you eat in a day?_____

Caffeine use? YES / NO — If Yes, Coffee, Tea, Cola?_____ How many cups/cans per day? _____

Alcohol use? YES / NO — If Yes, what kind? _____ How many drinks per week? _____

Sexually active? YES / NO — If Yes, are you and your partner trying for pregnancy? _____

If not trying for pregnancy, please list contraceptive or barrier method:_____

_____

Any discomfort with intercourse? YES / NO

If Yes, please add details: _____

Smoking History

Do you smoke? YES / NO — Smoking start date_____ Smoking end date_____

Frequency_____ Packs per week? _____

Other Tobacco? YES/NO — What type of tobacco? _____ How much/many a day? _____

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Allergies *(Check one & list allergies if applicable)*
___ Unknown
___ No Known Allergies
___ Has Allergies
List Allergies:_____
_____
_____

Medications: *(Please list the **EXACT NAME** of prescription, dosage & frequency; this helps prevent our staff from listing the incorrect medications on your chart.)*

Name of Medication	**Dosage (ex: 10mg,20mcg)**	**Frequency (ex: 1 tablet twice daily)**

Immunizations *(List all immunizations/vaccines & dates received)*

Immunization/Vaccine	Date received

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave you voicemails regarding your medical information?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If **YES**, please list the name(s) & relation of members allowed:

_____

_____

_____

Signature:_____ Date: _____

Print Name:_____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing this form, I,_____ am authorizing and granting consent to Reliance Health & Wellness, LLC to retrieve, use and disclose my health information to and/or from the following:

Doctors Office: _____

Hospital: _____

Hospital: _____

Facility: _____

Facility: _____

The type and amount of information to be disclosed is as follows:

_____ Complete Health Records
_____ Physical Exams
_____ Lab Results
_____ Consultation Reports
_____ Appointments
_____ Billing Information
_____ Procedure Reports

I understand I have the right to revoke this authorization at any time by submitting the request in writing to Reliance Health & Wellness Solutions.

Patient Name: _____ DOB:_____

Patient Signature:_____ Date:_____

Effective Date:_____

FMLA FORMS

Family and Medical Leave Act provides up to 12 unpaid weeks of job-protected leave per year for medical condition(s) that have been addressed and/or treated by the physician. Please allow 5-7 business days to process. Reliance Health & Wellness Solutions reserves the right to charge a reasonable fee for $65 for the completion of the requested forms. This fee is subject to change, please verify with the staff for the updated amount due.

MEDICAL RECORDS

Reliance Health & Wellness Solutions reserves the right to charge for the reasonable cost of $.10 cents per page for copying and/or mailing the records at your request. If you are requesting your medical records to be transferred from Reliance Health & Wellness Solutions to another provider, we will satisfy your request once we have received the request from your authorized provider at no cost to you.

ADVANCED DIRECTIVE (LIVING WILL)

Do you have an advanced directive? _____

Would you like to keep a copy on the chart?_____

PAYMENT AUTHORIZATION

I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to the physician. I further authorize the release of any and all medical or other information to such services to my insurance carrier in order to determine benefits due to me. I agree to be personally and fully responsible for payment for medical services rendered. I understand that if I cancel a scheduled appointment, it must be within regular clinic hours at least on day prior to my appointment, or a $35 surcharge will be required prior to attending any future appointments. I consent to receive calls from Reliance Health & Wellness Solutions for my protected healthcare and other services at the phone number listed in my patient registration form.

AGREEMENT and ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of Reliance Health & Wellness Solutions and I agree to abide by its terms.

I hereby assign all medical benefits and authorize my insurance carrier(s) to issue the payment directly to Reliance Health & Wellness Solutions.

I understand that I am financially responsible and binding for all services I receive from Reliance Health & Wellness Solutions.

Print Name: _____

Signature: _____ **Date:** _____

Credit/Debit card information for No Show/Missed appointment fee

Name on Card: _____

Credit card #: _____ Card Type: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Patients Rights & Responsibilities

It is the policy of Reliance Health & Wellness Solutions to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. We make every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

ISSUES OF CARE

Reliance Health & Wellness Solutions is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

PATIENT RIGHTS

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.

4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

PATIENT RESPONSIBILITIES

1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.

2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.

3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

4. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

By signing this form, you have read and agree to the above.

Patient Name:_____

Patient Signature:_____ Date:_____