NEVAEH HEALTH & WELLNESS CENTER, PLLC

538 3RD Ave., South Charleston, WV 25303
304-362-9883 – Office

First Name: _____ Middle: _____ Last: _____
Address: _____ City: _____ St: _____ Zip: _____
Date of Birth: _____ Home Phone: (____)-_____ Cell: (____)-_____
SSN#: _____
Employer: _____ Business Phone: (____)-_____
Business Address: _____
Occupation: _____ Referred By: _____
Emergency Contact: _____ Relationship: _____ Phone: (____)-_____

Insurance Name: _____ ID#: _____ Group#: _____
Insurance Claims Address: _____
Insured – First, Middle, Last Name: _____ Insured D.O.B: _____
Insured Employer: _____ Insured Business Phone: (____)-_____
Insured Business Address: _____ Insured SSN#: _____
Relationship to Patient: _____ Insured Home Phone: (____)-_____
Insured Home Address: _____

***Release of information, Benefit Assignment, Payment Authorization, Full Disclosure Statement, and Agreement to pay for Professional Services*:**

I hereby authorize Nevaeh Health & Wellness Center, PLLC (Dr. Kristi Hensley) to release any information necessary to process my insurance/Medicare claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance/ Medicare for the period of LIFETIME. I claim any insurance benefits due to me for services rendered by Nevaeh Health & Wellness Center, PLLC regardless of my insurance benefits, if any. I understand, that I am fully financially responsible for any and all fees incurred, and I agree to pay such fee in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand, that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for the professional charges, as a result of non-payment by any carrier.

Patient/Responsible Party Signature: _____ Date: _____

CANCELLATION POLICY

There will be a $15 cancellation fee if our office in not notified that you are unable to keep your appointment.

INSURANCE POLICY

It is the responsibility of the patient to make sure that **Nevaeh Health & Wellness Center, Elizabeth Kristi Hensley, M.D.** is in network with your chosen insurance plan. Any balance incurred will be the responsibility of the patient.

Patient Signature: _____ Date: _____

NEVAEH HEALTH & WELLNESS CENTER, PLLC

Name: _____ Date of Birth: _____
Previous Physician(s): _____
Current Medical Problems: _____
_____
Hospitalizations (including reason and date): _____
_____
_____
Prior Surgeries (including year): _____
_____
Current Medications (including dose and number of times taken per day): _____
_____
_____
Medication Allergies (including type of allergic reaction which occurs): _____
_____
_____

Sex: Male Female **(Please circle one**)

Social History:
Married _____ Single _____ Divorced _____ Widow/Widower _____

Number of Children? _____

Occupation: _____ For how many years? _____

Do you smoke cigarettes? _____ Cigars _____ Pipe tobacco _____ E-cigs ____

IF YES, how much per day? _____

IF NO, have you ever smoked? _____ When did you quit? _____

Do you use smokeless tobacco products? _____ IF YES, how much per day? _____

Do you drink beer or liquor? _____ IF YES, how much per week? _____

Do you drink coffee? _____ IF YES, how much per day? _____

Do you drink other caffeinated beverages? _____ IF YES, how much per day? _____

LIVING WILL/ADVANCE DIRECTIVES: **(Circle One)** YES NO

PATIENTS NAME: _____ Date of Birth: _____

Family History:

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
Alcoholism						
Allergies						
Anemia						
Arthritis						
Bleeding Disorder						
Cancer						
Diabetes						
Depression						
Glaucoma						
Epilepsy/Seizure						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Migraine						
Osteoporosis						
Stomach Ulcer						
Stroke						
Suicide Attempt						
Thyroid Disease						
Other						

Date: _____

MEDICAL INFORMATION RELEASE FORM
HIPAA RELEASE FORM

I, _____ give my permission for Nevaeh Health & Wellness Center, PLLC (Dr. Kristi Hensley) to release any information regarding my medical history, including any test results, appointments, and medications to those listed below:

NONE/ NO ONE – **(Circle One)**

_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____
_____ Relationship:_____ Phone: _____

***This release of information will remain in effect until terminated by me in writing. ***

Patient Signature: _____ Date: _____

Nevaeh Health & Wellness Center, PLLC
Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Nevaeh Health & Wellness Center, PLLC may use and disclose **Protected Health Information (PHI)** about me in order to carry out **Treatment, Payment and Healthcare Operations (TPO)**. A more complete description of such uses and disclosures can be found in the Notice of Privacy Practices for Nevaeh Health & Wellness Center, PLLC.

I have the right to review the aforementioned Notice of Privacy Practices prior to signing the consent. Nevaeh Health & Wellness Center, PLLC 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 the Privacy Officer at Nevaeh Health & Wellness Center, PLLC, 538 3rd Ave., South Charleston, WV 25303

With my consent, a representative of Nevaeh Health & Wellness Center, PLLC may call my home or other designated location and leave a message on an answering machine, voice mail, text message, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including lab results.

With my consent, Nevaeh Health & Wellness Center, PLLC may mail to my home or other designated location any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Nevaeh Health & Wellness Center, PLLC restrict how it uses or discloses PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, such uses and disclosures are bound by this agreement. I have such restrictions indicated below:

_____

_____

_____

_____

By signing this form, I am consenting to Nevaeh Health & Wellness Center, PLLC's use and disclosure of 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 to my prior consent. If I do no sign this consent, Nevaeh Health Center, PLLC may decline to provide treatment to me. By signing this form, I also acknowledge that I have received and reviewed the Notice of Privacy Practices (NPP) for Nevaeh Health & Wellness Center, PLLC.

Patient Signature: _____ Date: _____

Nevaeh Health & Wellness Center, PLLC

Patient Consent for Use and Disclosure of Protected Health Information – (Continued – Page 2)

Patient's Name: _____
Address: _____
Birth Date: _____ SSN: _____Phone: _____

I authorize: _____ *(Physician Name)*
Street Address: _____
City: _____ State: _____ Zip: _____

To release my Protected Health Information (PHI) to:
Nevaeh Health & Wellness Center, PLLC, 538 3rd Ave., South Charleston, WV 25303

This Authorization expires on: _____

The specific information to be released includes the following:

____ Staff/Progress Notes	____ Radiology Reports	____ HIV
____ Immunization Records	____ Pathology Reports	____ Substance Abuse
____ Laboratory Studies	____ Behavioral Health/Psychiatric	

____ Other: _____

Special Instructions: _____

DO NOT RELEASE:

____HIV ____Substance Abuse ____Behavioral Health/Psychiatric ____Other

- I understand, I do not have to sign this authorization in order to receive health care (treatment, payment, or enrollment) and that I may refuse to sign this authorization. However, I do have to sign an authorization form to:
  - take part in a research or study; or
  -receive health care for the express purpose of creating health care information for a third-party (i.e. – life insurance physical, etc.)
- I understand, I have the right to inspect or copy the PHI (Protected Health Information) to be used or disclosed by Nevaeh Health & Wellness Center, PLLC pursuant to this authorization. I also understand revocation will not be effective as to the use and/or disclosure of information I have previously authorized or where other action has been taken in reliance on authorization I have signed.
- I understand, information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state laws protesting its confidentiality.

Nevaeh Health & Wellness Center, PLLC

Patient Consent for Use and Disclosure of Protected Health Information – (Continued – Page 3)

Please complete above portion (Pg. 2) of form entirely; signature and witness required:

I fully understand and accept the terms of this authorization:

_____ _____

(Signature of Patient or Representative) (Printed Name of Patient or Representative)

Date: _____ _____

(Signature of Witness and Title)

APPOINTMENT CONFIRMATION

Which form(s) of contact would you like to receive from our office regarding appointments/lab?

Patient Name: _____ DOB: _____
Consent to contact for appointment: (Check all that apply)
____ **Email** reminders and messaging
Email address: _____
____ **SMS mobile text** reminders and messaging
Cell Phone: _____
____ **Voice reminders** and messaging
Cell/Home Phone: _____

MESSAGES

Messages may be left at: ____ My home ____ My work ____My cell ____ By Mail
If you are unable to reach me:
____ you may leave a detailed message
____ please leave a message asking me to return your call
____ Other: _____