HealthWise Clinic

2301 S. FM 51, Suite 500, Decatur, Texas 76234
Phone: (940) 627-0013 ❖ Fax: (940) 627-1900

John Richardson, MD

Board Certified in Family Practice & Geriatrics

PATIENT INFORMATION

Name: _____
Last First Middle Initial

SS#: _____DOB: _____ Age: ____Sex: ___ Race/Ethnicity: ____Language:_____

Mailing Address: _____
Street/PO Box City Zip Code

Home Phone: _____ Cell Phone: _____
(Text appt reminders etc.)

Work Phone: _____ Email: _____

Web Enable: Yes / No (allows access to appointment dates, lab results, visit summaries, etc.)

Local Pharmacy Name:_____ Pharmacy City:_____

Mail Order Pharmacy Name: _____

Circle Preferred Method of Contact: Phone Call Text Message Email

Morning Afternoon Evening

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Alternate Phone: _____

INSURANCE BENEFITS ASSIGNMENT AND INFORMATION RELEASE

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand that I am responsible for copay and coinsurance payments at the time services are rendered. I also understand that if my services are not covered by my insurance I will be responsible for any remaining balances. If I do not have insurance and I am private pay, I understand that I am responsible for payment at the time services are rendered.

Signature: _____ Date: _____

PRIVACY POLICY NOTICE

I have read and agree to the Notice of Privacy Policy Policies for HealthWise Clinic.

Signature: _____ Date: _____

OFFICE POLICIES NOTICE

I have read and agree to the Patient Guide to HealthWise Office Policies.

Signature: _____ Date: _____

Patient and Parent Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, (patient name)_____, understand that as part of my health care, HealthWise Clinic, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that HealthWise Clinic, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that HealthWise Clinic, P.A. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should this office change its notice, it will provide a copy of the Notice to me at a subsequent visit.

I wish to **authorize** and/or add the following **restrictions to the use or disclosure of my health information:**
_____
_____
_____
_____I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____ _____

Patient or Caregiver's Signature **If caregiver, relationship to patient**

Date_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

SS#: _____ DOB: _____

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

☒ Continuing Medical Care	☐ Military	☐ Social Sec./Disability
☐ Insurance	☐ Personal Use	☐ Other: _____
☐ Legal Purposes	☐ School	

INFORMATION TO BE RELEASED:

☒ History & Physical	☒ Consultation Report	☒ Hospital Reports
☒ Operative Reports	☒ Discharge Summary	☐ Other: _____
	☒ X-ray Reports/Images	

RELEASE TO: (Name of physician or facility receiving information)

Dr. John Richardson (940) 627-0013
(Doctor, Hospital, Attorney, Insurance Company, Self, Other…) Phone Number

2301 S FM 51, Suite 500, Decatur, Texas 76234 (940) 627-1900
Address (Street, City, State, Zip Code) Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorizations, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs or the authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Law.

This authorization will expire in One Hundred Eighty Days (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

_____ _____
Date Signature Patient or Legally Authorized Representative

_____ _____
Relationship to patient Printed name of above signed

Health Risk Assessment (HRA)

Name: _____ **Date:**_____

Date of Birth: _____ **Preferred language:**_____

Form completed by: □ Self □ Friend/family □ Office staff □ Other _____

How do you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are there any changes in your medical history since last year? ☐ Yes ☐ No (if yes, list)

On how many days during the week do you…? (Circle the appropriate answer below)

1) Do physical activity (e.g. walking, sports, etc.) for at least 30 minutes?	0	1 - 2	3 - 4	≥5
2) Include strength exercises (weights or bands) in your physical activity routine?	0	1 - 2	3 - 4	>5
3) Eat 5 or more servings of fruits and vegetables (one serving equals ½ cup)?	0	1 - 2	3 - 4	≥5
4) Eat 5 or more servings of grains (one serving equals one slice of bread, ½ cup of cereal, etc.)?	0	1 - 2	3 - 4	>5
5) Eat 2 or more servings of dairy products (milk, yogurt or cheese)?	0	1 - 2	3 - 4	≥5
6) Eat fast food?	0	1 - 2	3 - 4	≥5
7) Cut the size of your meals or skip meals because you don't have enough food (not enough money or enough help to shop or cook)?	0	1 - 2	3 - 4	>5 _
8) Have more than one drink of alcohol (beer, liquor, wine) per day?	0	1 - 2	3 - 4	≥5
9) Get at least 7 hours of sleep?	0	1 - 2	3 - 4	≥5
10) Use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes) or are close to others who do?	0	1 - 2	3 - 4	>5
11) Leave your home to run errands, go to work, go to meetings, classes, church, social functions, etc. (not counting doctor's visits)?	0	1 - 2	3 - 4	>5 _
12) Have physical pain that affects your activities?	0	1 - 2	3 - 4	≥5

13) Do you have mouth or tooth problems that make it difficult to eat?	☐ Yes	☐ No
14) Do you have enough money to pay for your medicines, medical supplies, and medical care?	☐ Yes	☐ No
15) About how many times **in the last month** have you…		
...missed taking your medicines?	_____times	
...taken your medicines differently than prescribed by your doctor?	_____times	
...taken any over-the-counter medicines (non-prescription medicines, supplements or herbal medicines)?	_____times	
16) Do you drive?	☐ Yes	☐ No
If no, are you able to get where you need to go?	☐ Yes	☐ No
17) Are you sexually active? (if yes, # partners in last 12 months)	☐ Yes	☐ No
18) Do you have problems hearing or seeing? (if yes, circle which one)	☐ Yes	☐ No
19) In the **past 12 months**, have you had any problem with balance or walking, or have you had any falls? If yes to falls, how many falls? _____	☐ Yes	☐ No
Are you concerned about falling?	☐ Yes	☐ No
20) Are you or your family concerned about your memory?	☐ Yes	☐ No
21) In the **past 6 months**, have you had a problem with leakage of urine?	☐ Yes	☐ No
22) In the **past month**, have you needed help managing your finances?	☐ Yes	☐ No
23) Do you think anybody is taking or using your money without your permission?	☐ Yes	☐ No
24) In the **past 7 days**, have you needed help from others…		
….to eat, bathe, get dressed or use the toilet?	☐ Yes	☐ No
….to do laundry, cooking, housekeeping or shopping?	☐ Yes	☐ No
….to take your medicines?	☐ Yes	☐ No
25) Do you or your caregiver have enough help/support for caregiving duties? (skip if you do not give or receive care)	☐ Yes	☐ No
26) Are you often lonely?	☐ Yes	☐ No
27) Do you have family and friends who care about you and you can count on for help when you need something or have a problem?	☐ Yes	☐ No
28) Is anybody hurting (hitting or yelling) or not taking care of you?	☐ Yes	☐ No
29) Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	> Half of the Days	Nearly Every Day
33) Anxiety or stress about your health, money, family, friends or work?	☐	☐	☐	☐
34) Little interest or pleasure in doing things?	☐	☐	☐	☐
35) Feeling down, depressed or hopeless?	☐	☐	☐	☐

List of Medicines and Supplements You Take

Name of medicine/supplement	Dose and how often taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Other healthcare providers you see (and their specialty)	
1.	5.
2.	6.
3.	7.
4.	8.

Medical supplies you receive (e.g. oxygen) and who supplies it: