Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

THE HIGHLAND WELLNESS CENTER

PATIENT INFORMATION/DEMOGRAPHIC FORM

Date: _____

PATIENT NAME: _____ Prefer to be called / Nickname

_____

Date of Birth: _____ Emergency Contacts Name: _____

Phone #_____

Patient Mailing Address:

Street: _____

City: _____ State: _____ Zip: _____

Living Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Telephone / Contact Information

Home: _____ (Mobile # if no home phone) Work: _____ (If employed) Mobile: _____ (If you have a mobile #)

Email address: _____

Occupation: _____ Employer: _____

How did you hear about us?

- o Doctor Referral
- o Sign
- o Family or Friend _____
- o Facebook
- o Email
- o Insurance Company
- o Other _____

PLEASE READ & SIGN

**** *Failure to cancel appointments without 24-hour notice will result in full appointment fee.* ****

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

_____

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

_____

Signature *Date*

02/06

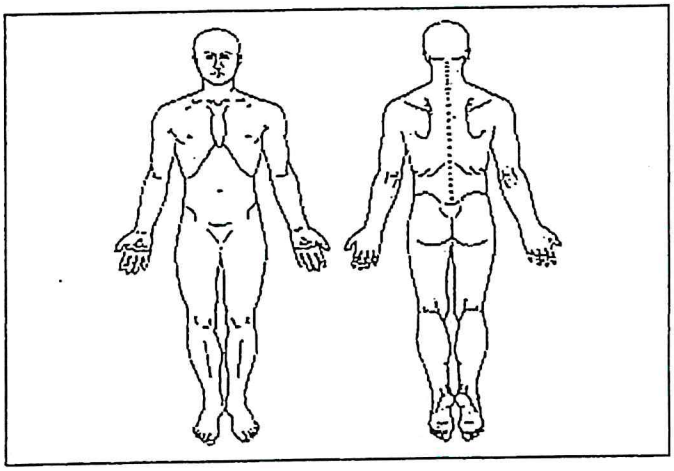
NAME_____ DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

Name: _____ Date:_____

PERSONAL HISTORY

Please mark the box with an X if it applies to you. In categories with multiple selections, please circle which applies to you, mark an X for all.

Has any blood relative ever had:

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems
- ☐ Cancer
- ☐ Hypoglycemia

Have you ever had problems with:

- ☐ Weight changes, gained or lost in past 5 years.
- ☐ Fever, chills, sweats.
- ☐ Allergy, asthma.
- ☐ Anemia, bleeding, bruising.
- ☐ Thyroid problems, heat or cold intolerance.
- ☐ Diabetes
- ☐ Eye problems (glasses, glaucoma etc.)
- ☐ Ear problems (ringing, deafness, ear infections).
- ☐ Nose/Throat problems (sinus, nosebleeds, hoarseness).
- ☐ Dizziness
- ☐ Jaw (TMJ) or dental problems
- ☐ Nausea or Vomiting.
- ☐ Stomach Problems (ulcer, indigestion, heartburn, hiatal hernia).
- ☐ Abdominal pain or swelling.
- ☐ Diarrhea or constipation.

How often do you have a bowel movement? _____

Do you experience:

- ☐ Tarry/black stool or blood in stool.
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Liver or gall bladder problems.

Do you drink alcohol? _____ How many drinks per week? _____

Do you smoke? _____ How many years? _____ How many packs? _____

Do you currently experience:

- ☐ Shortness of breath, wheezing.
- ☐ Lung problems (coughing, phlegm, infection, pneumonia, tuberculosis).
- ☐ Occupational or environmental inhalation.

- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations in heart
- ☐ High Blood Pressure
- ☐ Rheumatic fever
- ☐ Urinary problems (frequent, painful, or dribbling urination).
- ☐ Blood in urine.
- ☐ Bladder or kidney problems.
- ☐ Sexually transmitted disease.
- ☐ Testicle mass or pain.
- ☐ Breast lump, pain, or nipple discharge.

Have you ever experienced:

- ☐ Skin itching or rash.
- ☐ Skin Cancer
- ☐ Headaches
- ☐ Seizures
- ☐ Head trauma
- ☐ Stroke
- ☐ Joint pain, swelling, or stiffness
- ☐ Neck Pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Arm or leg problems
- ☐ Fractures, dislocations, or sprains. Where and when? _____
- ☐ Car accidents, falls, or injuries. When? _____
- ☐ Drug abuse
- ☐ Psychiatric problems, anxiety, depression.
- ☐ Shoe lifts or inserts.
- ☐ Poor sleep quality. How many hours per night? _____

FOR FEMALES:

- ☐ Menstrual problems.
- ☐ Pelvic pain, abnormal vaginal discharge.
- ☐ Ovarian cyst.
- ☐ Menopause. At what age? _____
- ☐ Menstrual flow.
    - o How many days does a typical period last? _____
    - o How many days in between cycles? _____
    - o Date of last period: _____
    - o Date of last PAP: _____

List all hospitalizations, surgeries, or diseases and dates.

List current medications and vitamins/supplements.

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month.**
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____