Initials_____ Pt#_____

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PATIENT INFORMATION

What language do you speak? ☐ English ☐Spanish ☐Other _____ What language do you write? ☐English ☐Spanish ☐Other _____ Did someone complete this form on your behalf? ☐Yes ☐No **SI NECECITA ESTA FORMA EN ESPAÑOL POR FAVOR AVISENOS.**	**Today's Date:** **Social Security #**	**Agency Use Only:** ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐100% Self Pay Annual Income $_____ Household size_____ Eligible from _____thru_____

Legal Last Name	**First Name, Middle Initial**	**Birth Date**	**Gender** M F	Other/Former/Maiden Name(s)
Physical Address	**City**	**State**	**Zip Code**	**County**
Mailing Address/P.O. Box	**City**	**State**	**Zip Code**	**County**
Home Phone	**Message Phone**	**Are you a U.S. Citizen?** ☐Yes ☐No		**Marital Status (check one)** ☐Never Married ☐Married ☐Divorced ☐ Legally Separated ☐Widowed ☐Minor Child
Cell Phone	**Work Number**	**Email Address**		

Race (check all that apply)	**Ethnicity (check one)**	**Housing Information** (check one)	**Are you a Veteran?**
☐Asian ☐African American ☐American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Other/Multi Racial ☐ White ☐Decline to answer ☐ Unavailable	☐Not Hispanic ☐Hispanic/Latino ☐ Ethnic Black ☐Decline to answer ☐ Unavailable	☐Own ☐Rent ☐HUD/CHA ☐Homeless ☐Rent Free ☐Group Home	☐No ☐Non-Combat ☐Combat

Employment (check one):	Employer Name	Employer Phone Number
☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student ☐Disabled ☐Retired	Employer Address	Date Hired

(For Dependents, Only) Name of Parent/Guardian	**Patient place of birth (state)**	**May we leave you a voice mail message for future appointments?** ☐YES ☐NO

Annual Income		**Household Size**
☐$0 - $10,000	☐$40,000 - $50,000	_____
☐ $10,000 - $20,000	☐$60,000 - $70,000	
☐$20,000 - $30,000	☐ over $70,000	
☐ $30,000- $40,000		

How did you hear about us?
☐Existing Patient
☐Referral from another provider
☐Referral from family/friend
☐Social Media
☐Traders Shoppers Guide

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INSURANCE INFORMATION

Health Insurance? ☐Yes ☐No	Medicare if yes please include policy # ☐Yes ☐No	Equality Care/Medicaid if yes please include policy # ☐Yes ☐No	Kid Care if yes please include policy # ☐Yes ☐No	Prescription Coverage ☐Yes ☐No
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐Yes ☐No		Medicare Part D ☐Yes ☐No	If unemployed, are you eligible for COBRA benefits? ☐Yes ☐No	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Are you seeking medical care because of an accident? ☐Yes ☐No If yes, answer following questions…

Date of accident: / /	Was it a motor vehicle accident? ☐Yes ☐No	Was the accident work related? ☐Yes ☐No	Where did the accident occur?
Workers Compensation number:	If motor vehicle accident, name of auto insurance company and policy number:		Do you have an attorney involved and/or a settlement pending? ☐Yes ☐No

ASSIGNMENT AND RELEASE: I authorize HealthWorks to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to HealthWorks that otherwise might be payable to me for services rendered. I understand HealthWorks may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or another medical carrier. I understand that HealthWorks will file an initial claim with Medicare, Medicaid, or any other third party insurance, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all my charges whether they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service**.** If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current HealthWorks reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party: _____ **Print Patient Name: _____**

Relationship to Patient: _____ **Date: _____**

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Cheyenne Health and Wellness Center (CHWC)

(DBA: HealthWorks, and Prescription Assistance Program (PAP)

CONSENT FOR TREATMENT

Health and Medical Care Consent: I voluntarily consent to and authorize Cheyenne Health and Wellness Center, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my physician, his/her designees. CHWC periodically conducts training programs for health care professionals. These persons may be observing or participating in CHWC's treatment programs. They will be under the direction of supervised licensed professionals. I understand that I have the right to refuse to have trainers or students participate in my care.

Wyoming Immunization Registry: I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide timely notification of immunizations due, and to serve as a backup in case you lose your record of vaccination(s). Immunization records are only accessible by authorized health care providers, and schools.

☐ I authorize CHWC to enter information regarding my (or my child's) immunizations into the Wyoming Immunization Registry.

☐ I choose to no longer have myself (or my child) participate in the Wyoming Immunization Registry and request that my (or my child's) immunizations be removed from the Wyoming Immunization Registry.

Printed Name of Patient: _____

Patient or Authorized Signature: _____**Date**_____

If patient is unable to sign or is a minor, indicate relationship to patient: _____

Emergency contact information: In case of emergency who should we contact?

Name: _____ **Phone: (____) _____-_____** **Relationship to patient:** _____

ACKNOWLEDGEMENT OF PRACTICE'S NOTICE OF PRIVACY PRACTICE

CHWC is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. By subscribing my name below, I acknowledge that I was provided a copy of the NPP and that I have read (or had the opportunity to read if I so choose) and understand the NPP and agree to its terms.

Patient or Authorized Signature_____**Date**_____

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AUTHORIZATION TO DISCLOSE INFORMATION

For HealthWorks to share your health information with a family member (such as a spouse, parent, child, friend); you must first give HealthWorks written permission to do so. By filling out and signing this form, you give that permission. Healthworks may then share your health information with the individuals whose names you have listed in the "CONTACT" section.

Patient Name: _____

Street Address: _____

City, State, Zip:_____

Home phone: _____ Alternate Phone: _____

I hereby authorize HealthWorks to disclose health information to the following contacts:

CONTACT #1 NAME: _____ RELATIONSHIP _____

Street Address:_____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

CONTACT #2 NAME: _____ RELATIONSHIP TO ME _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

The information that may be disclosed or discussed:

☐ **All my information**

☐ **All my information (except HIV, mental health, and substance abuse)**

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

By signing this form, I understand that HealthWorks may discuss past, present, or future health care issues with these contact(s) from:

Start date _____ through _____ (end date to not exceed 1 year)

SIGNATURE: _____ Date: _____