WAVERLY
Health Care
URGENT CARE
& Family Practice

# Adult Health History

**PATIENT INFORMATION**

| | |
|---|---|
| Name: | Date: |
| Date of Birth: | Age: |
| Address 1: | Social Security #: |
| Address 2: | Sex: |
| City: | Language: |
| State: Zip: | Employer: |
| Home phone: | Emergency Contact: |
| Work phone: | Emergency Phone: |
| Cell phone: | Emergency Relationship: |

**GUARANTOR INFORMATION (Person whom is financially responsible for the account)**

| | |
|---|---|
| Name: | Date of Birth: |
| Address 1: | Social Security #: |
| Address 2: | Sex: |
| City: | Language: |
| State: Zip: | Employer: |
| Home phone: | Emergency Contact: |
| Work phone: | Emergency Phone: |
| Cell phone: | Emergency Relationship: |

**INSURANCE INFORMATION**

| | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| Certificate #: | Certificate #: |
| Group #: | Group #: |
| Group Name: | Group Name: |
| Copay: | Copay: |
| Subscriber Name: | Subscriber Name: |
| Social Security #: | Social Security #: |
| DOB: | DOB: |

**Authorization to Pay Benefits to Physician**: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Waverly Health Care Urgent Care, when he/she accepts assignment.

**Authorization to Release Medical Information**: I hereby authorize my Provider, Waverly Health Care Urgent Care, to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

***Please provide your pharmacy:_____***

Name:_____ Sex: M F Date:_____

Age:_____ DOB:_____ Marital Status: S M D W Occupation:_____

Spouse's Name:_____ Occupation:_____

Children's Names and Ages:_____
_____

Current Medical Problem:_____
_____

Past or Present (*on going)* Medical Problems:_____
_____

Surgeries & Dates:_____
_____
_____

Immunizations: (*give date of most recent immunization)*
Tetanus_____Influenza_____Pneumonia (pneumovax)_____

| Current Medications: | Dosage: | How Often: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List Any Allergies to Medications and/or Other Substances:
_____Reaction:_____
_____Reaction:_____

Family History: (*Indicate maternal or paternal relatives with any of the following problems)*
Heart Disease:_____
High Blood Pressure:_____
Diabetes:_____
Cancer: (Include type)_____
Other Inherited Diseases:_____
Emotional Problems:_____

Health Habits: (*Circle most appropriate and fill in blank)*

| | | | | |
|---|---|---|---|---|
| Tobacco Use: | Never | In The Past | Now | |
| Type of tobacco::_____ | How Much:_____ | How Long:_____ | | |
| Alcohol: | Never | Rarely | Frequently | How Much:_____ |
| Street Drugs: | Never | Rarely | Frequently | What:_____ |
| Exercise: | Never | Rarely | Frequently | How Often:_____ |
| Seatbelt: | Never | Sometimes | Always | |
| Eating: | Poorly | Meets Needs | Excessively | |
| Caffeine: | Never | Sometimes | Frequently | How Much:_____ |

Approximate number of hours of sleep per night?:_____

Name:_____Todays Date:_____

Have you had any of the following problems: (Include current and past problems) **Mark with X current symptoms, √ for past symptoms**

| **General** | **Current** | **Past** |
|---|---|---|
| Weight Gain | _____ | _____ |
| Weight Loss | _____ | _____ |
| Appetite Loss | _____ | _____ |
| Chills/Fever | _____ | _____ |
| Fatigue | _____ | _____ |
| Sleep Difficulties | _____ | _____ |
| Lymph Gland Swelling/Lumps | _____ | _____ |

| **HEENT** | **Current** | **Past** |
|---|---|---|
| Frequent Headaches | _____ | _____ |
| Recent Changes in vision | _____ | _____ |
| Glaucoma | _____ | _____ |
| Cataract | _____ | _____ |
| Hearing Loss | _____ | _____ |
| Ringing in the Ears | _____ | _____ |
| Frequent Nosebleeds | _____ | _____ |
| Persistent Hoarseness | _____ | _____ |
| Difficulty Swallowing | _____ | _____ |
| Sore Throat | _____ | _____ |

| **Respiratory** | **Current** | **Past** |
|---|---|---|
| Frequent cough | _____ | _____ |
| Snoring | _____ | _____ |
| Asthma | _____ | _____ |
| Emphysema | _____ | _____ |
| Shortness of Breath | _____ | _____ |
| Coughing up Blood | _____ | _____ |
| Coughing up Phlegm | _____ | _____ |
| Tuberculosis | _____ | _____ |
| Recurrent Pneumonia | _____ | _____ |
| Recurrent Bronchitis | _____ | _____ |

| **Genitourinary** | **Current** | **Past** |
|---|---|---|
| Blood in Urine | _____ | _____ |
| Difficulty Starting Urine | _____ | _____ |
| Burning with Urination | _____ | _____ |
| Urinary Frequency | _____ | _____ |
| Urinary Incontinence | _____ | _____ |
| Slow Urine Flow | _____ | _____ |
| Bladder Infections | _____ | _____ |
| Kidney Infections | _____ | _____ |
| Kidney Stones | _____ | _____ |
| Venereal Disease | _____ | _____ |
| *Men* | | |
| Prostate Problems | _____ | _____ |
| Discharge from Penis | _____ | _____ |
| Lump in Testicles | _____ | _____ |
| *Women* | | |
| Vaginal Discharge | _____ | _____ |
| Irregular Periods | _____ | _____ |
| Painful Periods | _____ | _____ |
| Pain with intercourse | _____ | _____ |
| Abnormal Vaginal Bleeding | _____ | _____ |
| Abnormal PAP Test | _____ | _____ |

Date of last PAP _____/_____/_____
Age of Onset of Periods: _____
Total # of days in Cycle:_____Days of Flow:_____
Number of Pregnancies_____ Number of Children_____
Method of Birth Control:_____

| **Endocrine** | **Current** | **Past** |
|---|---|---|
| Thyroid problems | _____ | _____ |
| Excessive thirst or urination | _____ | _____ |
| Diabetes/High Blood Sugar | _____ | _____ |

| **Skin** | **Current** | **Past** |
|---|---|---|
| Excessive Sweating | _____ | _____ |
| Rash | _____ | _____ |

| **Neck** | **Current** | **Past** |
|---|---|---|
| Neck Pain | _____ | _____ |
| Neck Stiffness | _____ | _____ |

| **Breast** | **Current** | **Past** |
|---|---|---|
| Breast Pain | _____ | _____ |
| Nipple Discharge | _____ | _____ |
| Breast Lump | _____ | _____ |

| **Cardiovascular** | | |
|---|---|---|
| Chest Pain | _____ | _____ |
| Severe calf pain when walking | _____ | _____ |
| Shortness of Breath with exercise | _____ | _____ |
| Irregular Heartbeat | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Palpitations/Heart Racing | _____ | _____ |
| Waking at night due to | _____ | _____ |
| Shortness of Breath | _____ | _____ |
| Heart Attack | _____ | _____ |
| History of Heart Failure | _____ | _____ |
| Rheumatic Fever | _____ | _____ |
| Heart Murmur | _____ | _____ |

| **Gastrointestinal** | **Current** | **Past** |
|---|---|---|
| Hemorrhoids | _____ | _____ |
| Frequent Abdominal Pain | _____ | _____ |
| Black Tarry Stools | _____ | _____ |
| Recent Change in Bowel Habits | _____ | _____ |
| Constipation | _____ | _____ |
| Diarrhea | _____ | _____ |
| Vomiting Blood | _____ | _____ |
| Indigestion/Heartburn | _____ | _____ |
| Nausea | _____ | _____ |
| Rectal Bleeding/Bloody Stool | _____ | _____ |
| Vomiting | _____ | _____ |
| Hepatitis/Liver Problems | _____ | _____ |
| Gallbladder Problems | _____ | _____ |
| Ulcers | _____ | _____ |

| **Musculoskeletal** | **Current** | **Past** |
|---|---|---|
| Painful/Swollen Joints | _____ | _____ |
| Persistent Back or Neck Pain | _____ | _____ |
| Decreased Range of Motion | _____ | _____ |
| Muscle Pain | _____ | _____ |

| **Neurological** | **Current** | **Past** |
|---|---|---|
| Numbness in Face, Arms, Legs | _____ | _____ |
| Fainting/Loss of Consciousness | _____ | _____ |
| Seizures or Epilepsy | _____ | _____ |
| Previous Stroke | _____ | _____ |
| Weakness in Face, Arms, Legs | _____ | _____ |

| **Psychological** | **Current** | **Past** |
|---|---|---|
| Frequent Anxiety | _____ | _____ |
| Depression | _____ | _____ |
| Loss of Interest in Usual Activities | _____ | _____ |
| Recent Thoughts of Suicide | _____ | _____ |
| Suicide Attempt | _____ | _____ |

| **Hematology** | **Current** | **Past** |
|---|---|---|
| Abnormal Bleeding | _____ | _____ |
| Anemia | _____ | _____ |
| Blood Clots | _____ | _____ |

# Pine Lake Health, LLC & Waverly Health Care
# Patient Information

*(Please Print)*

**Patient Name: _____ DOB:_____**

**Receipt of Notice of Privacy Practice**

_____ I have been offered or received a copy of Pine Lake Health, LLC's Notice of Privacy Practices.
Initial

**Message Authorization**

Representatives of Pine Lake Health, LLC are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email. I realize this information may include pertinent health status and/or financial information.

□ DO NOT leave a message *(Check box if applicable)*

**Authorization to Communicate Personal Health Information:**

Pine Lake Health, LLC may communicate information to the following people regarding my health status as needed:

Name _____Phone Number _____ Relationship _____

Name _____Phone Number _____ Relationship _____

_____
Patient Authorized Signature

_____
Relationship to patient Date

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***For MEDICARE Patients ONLY***

**MEDICARE Authorization**

I request that payment of authorized MEDICARE benefits be made either to me, or, on my behalf, to Pine Lake Health, LLC for any services furnished to me by its physician. I authorize my holder of medical information to release to the Centers for MEDICAID and MEDICARE Services and its agents any information needed to determine these benefits or the benefits payable for related services.

**Secondary Insurance Benefits Authorization**

I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Pine Lake Health, LLC for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

_____
Patient Authorized Signature

_____
Relationship to patient Date

# *Pine Lake Health, LLC & Waverly Health Care*
# *Financial Policy and Patient Responsibilities*

Thank you for choosing Pine Lake Health, LLC as your primary health care provider. We are committed to assisting you with timely insurance filing and payment of your account. The following is a statement of our Financial Policy, which we require you to read and sign prior to initial visit.

Pine Lake Health, LLC is committed to providing the best treatment possible for our patients. Patients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our practice participates with many insurance plans and a current listing is available at each location and on our website www.pinelakehealth.com. If your insurance plan does not cover our services, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa, Discover, and debit cards.

Updated insurance information must be given to us at the time of service. We will require a copy of your insurance cards before services are performed and these will be scanned into our system. We file all insurance claims in a timely manner. After filing, we allow 30 business days for your insurance company to pay. If your insurance company fails to make payment, you will be responsible for payment in full.

If the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. We cannot become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee If you have a past due personal balance on your account, you will need to contact the billing office to make payment arrangements prior to receiving most services. Any account that is over 90 days past due will be sent to an independent collection service and may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship.

***Copays, Co-insurance and /or Deductibles –*** There may be some copay, co-insurance or deductible charges associated with certain medical services and tests. Patient payment of the copay, co-insurance, or deductible is required at the time of service.
***Pre-certification –*** Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. It is your responsibility to confirm that you have been granted approval of certification before your appointment so you do not incur any unnecessary personal charges.

***Other physician charges –*** Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as Pathology, Laboratory, and/or Radiology interpretation services, unless Pine Lake Health, LLC purchased these services.

***Motor Vehicle Accident*** – Medical insurance will be filed and any co pay, co-insurance or deductible is required to be paid at the time of service. If no payment is received from the insurance company after 30 business days, it will become the patient's responsibility. Filing claims to the auto insurance is the responsibility of the patient.

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***Unless contractually prohibited by your insurance carrier, you may be personally charged the following additional fees. These fees will not be filed to your insurance carrier and are the direct responsibility of the patient. Please initial to the left of each category to indicate your acknowledgement.***

_____ ***No Show Appointments & Returned Checks –*** Unless canceled at least 24 hours in advance,
(INITIAL) depending on the type of appointment, you may be charged a fee of $25.00 to $50.00 for each occurrence. After the 2nd no show appointment you will be dismissed from the practice. All returned checks will be charged a fee of $25.00 for each occurrence.

_____ ***Patient Billing Fee*** – Unless other suitable arrangements are made in advance, patients who fail to pay their co-payment,
(INITIAL) co-insurance, deductible, or estimated balance due at the time of service may be billed a fee up to $25.00 for each occurrence. I agreed to be billed a fee of 35% of a bad debt balance for any extraordinary costs associated with collection of funds owed to Pine Lake Health, including but not limited to, collection agency fees, attorneys' fees and court costs.

_____ ***Forms / Letters / Copy of Medical Records –*** There is a charge for completion of all forms, letters, or copying of medical records. (INITIAL) Payment must be made before the completion or release of any forms, letters, or medical records.
Forms for disability, FMLA and etc…will range $20.00 to $50.00. Letters may be billed up to a maximum of $40.00. Copying of medical records is charged of $5.00 handling fee plus $.25 per page.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about me to release to any third party payers (including Medicare and Medicaid) information needed for claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for the physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer, including Medicare and Medicaid, on my behalf. I request payment of benefits under Title XVIII (Medicare and XIX Medicaid) of the Social Security Act to Pine Lake Health, LLC. I understand that I am financially responsible for charges not covered by the assignment, and I hereby guarantee timely payment in full of any such charges.

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By signing below, I acknowledge that I have read and fully understand this Policy and my financial responsibilities as a patient of Pine Lake Health, LLC.

Print Patient Name: _____Date _____

Signature of Patient or Responsible Party _____