HAPPY HEALTH AND WELLNESS

Patient Information and Consent

Patient Information					
Name (First, Middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Employer (or parent/guardian employer if patient is a minor)				Work Phone	
Are you under the care of a Specialist? If yes, please give contact information					
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)		
Legal Name of Responsible Party (First, Middle, Last)	Social Security #	Date of Birth

Preferred Pharmacy	
Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Happy Health and Wellness

New Patient Information and Consent

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? ☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures, including immunizations, provided by Happy Health and Wellness and its associated physicians, clinicians and other personnel. By signing this consent, I also acknowledge and agree that in rendering care for me my physician, and/or her designees may chose to use products or services in which they have an ownership interest. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Happy Health and Wellness.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Happy Health and Wellness's Notice of Privacy Practices.
4. I authorize payment of medical benefits to Happy Health and Wellness physicians or their designer for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____

Patient's Signature Date

_____

Patient's Representative's Signature Date

_____

Print Patient Representative's Name & Relationship

_____

Witness Signature Date

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐Yes ☐ No Initial____

_____ _____

Patient or Authorized Person's Signature Date

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT HISTORY

No Past Conditions ☐

CHECK ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

☐ Heart disease	☐ Anemia or other blood disease	☐ Severe headaches	☐ Neck pain
☐ High blood pressure	☐ Thyroid disease	☐ Seizures	☐ Back pain
☐ High cholesterol	☐ Stomach disease	☐ Stroke	☐ Sleep apnea
☐ Lung disease	☐ Kidney, bladder or prostate disease	☐ Blood clots	☐ _____
☐ Diabetes	☐ Cancer (past or present)	☐ Depression	

ALLERGIES (include medication, food, latex and environmental allergies)

No Known Allergies ☐

Allergy to:	1. _____	2. _____	3. _____
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:	_____	_____	_____

CURRENT MEDICATION (include non-prescription products)

No Current Medication ☐

1. _____	3. _____	5. _____	7. _____
2. _____	4. _____	6. _____	8. _____

PROCEDURES/SURGERIES

Approximate Date	Surgery	Approximate Date	Surgery

FAMILY HISTORY

Mother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

OTHER HEALTH ISSUES

Do you drink alcohol? ..... ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor _____ per week

Do you smoke cigarettes? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use other forms of tobacco? ..... ☐ Yes ☐ No ☐ Pipe ☐ Cigar ☐ Snuff/Chew

Do you use an e-cigarette? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Marijuana / recreational drug use? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Review of Systems - Please Circle all that apply (past or present)

General/Constitutional:
Fatigue, Fever, Sleep Disturbance, Weight Gain, Weight loss

Allergy/Immunology:
Seasonal Allergies

Ophthalmolgic:
Blurred Vision, Itching, Eye Pain, Redness

ENT:
Decreased Hearing, Ear Pain, Nosebleed, Sinus Pain, Sore Throat, Swollen Glands

Endocrine:
Cold Intolerance, Sleep Difficulty, Excessive Thirst, Hair Loss

Respiratory:
Cough, Hemoptysis, Shortness of Breath, Wheezing

Cardiovascular:
Chest Pain, Heart Problems, Irregular Heartbeat, Palpitations, Swelling in Hands or feet

Gastrointestinal:
Abdominal Pain, Blood in Stool, Constipation, Diarrhea, Heartburn, Nausea Vomitting

Hematology:
Anemia, Bleeding Problems, Easy Bruising, Swollen Glands

Genitourinary:
Blood in Urine, Difficulty with Urination, Frequent Urination, Painful Urination

Musculoskeletal:
Back Problems, Joint Stiffness, Muscle Aches

Peripheral Vascular:
Cold Extremities, Painful Extremities

Skin:
Blistering of Skin, Dry Skin, Itching, Nail Changes

Neurologic:
Balance Difficulty, Dizziness, Headache, Memory Loss, Tingling/Numbness

Psychiatric:
Anxiety, Depressed Mood, Difficulty Sleeping

Cancer Management:
Breast Self-Exam, Colonoscopy, Mammogram, PAP, PSA, Skin Exam, Smoking Cessation

Recreational Drug Use
_____ Never Use
_____ Previous Use of
_____ Currently use:
_____

Any history of IV drug use?
____ Yes
____ No

If yes, please answer the following:

What Drug:
_____

Last Used:
_____

HAPPY HEALTH AND WELLNESS

Financial Policy
Patient Financial Agreement

Happy Health and Wellness is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Happy Health and Wellness will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

Your claims will be filed and processed under the business name Waco Functional Medicine which means your insurance explanation of benefits will show Waco Functional Medicine, not Happy Health and Wellness, as the facility.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

I have read and I understand Happy Health and Wellness' financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature	**Date**
Witness Signature	**Date**

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Happy Health and Wellness and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Happy Health and Wellness' services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Happy Health and Wellness is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give Happy Health and Wellness my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Happy Health and Wellness the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any canceled appointments in which a 24 hour notice was not given. There will be a fee of $50.00 for any missed office visits.

_____ (initial) I understand there will be a $35.00 fee for all returned Checks

_____ (initial) I understand that all services provided to me by Happy Health and Wellness are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Happy Health and Wellness has a contract with my insurance company. Happy Health and Wellness will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments and deductibles are not made at the time of service, I understand that my appointment may be no-showed.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Happy Health and Wellness my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Happy Health and Wellness pursuing any collection means possible.

I have read and I understand Happy Health and Welllness' financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Happy Health and Wellness. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until canceled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize Happy Health and Wellness to deposit checks received on my account when made out in my name.

I have read and I understand Happy Health and Wellness' financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

HAPPY HEALTH AND WELLNESS

PATIENT ATTENDANCE POLICY

At Happy Health and Wellness we strive to provide our patients with the excellent service and care. Our commitment to your well-being and gain in your health is something everyone in our clinic takes quite seriously. We pride ourselves on providing PERSONALIZED, ONE-ON-ONE care. In order to provide this level of service we reserve 30-minutes for EACH individual patient.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to your care and well-being. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain policies in place in order to ensure the most optimal results.

1. **CANCELLATIONS –** Consistent attendance and taking an active role in your treatment is one of the keys of improving your health and repeated last minute cancellations imply a lack of commitment to your health. Thus, if for any reason you must cancel an appointment our office requires **24-hour Advanced Notice.** Cancellations within the 24-hour period or appointments that are no showed are subject to a **$50.00 Late Cancellation or No Show Fee. Initial _____**

2. These fees must be paid personally – as your insurance does not cover charges for missed appointments. **Payment will be due at or prior to your next scheduled appointment. Initial _____**

3. **LATE ARRIVALS -** Arriving on time is also a critical part of delivering optimal care to our patients. Understandably, arriving late from time to time is an unavoidable part of life. However, if you arrive more than 15 minutes past your scheduled appointment time, you will be marked as a no show and you will be subject to the **$50.00 No Show Fee**. Please see line item 1 and 2 for information regarding fees and deadlines. **Initial _____**

I have read and understand the above policies, all my questions have been answered to my satisfaction and I agree to be bound as such.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Staff Signature/Title Date

WLM-1 2010-006

Medical Symptoms Questionnaire

Initials _____ **Number #** _____ **Visit #** _____ **Date** _____

Rate each of the following symptoms based on the last 48 hours:

Point Scale			
	0 *Never* or *almost never* have the symptom	3 *Frequently* have it, effect is *not severe*
	1 *Occasionally* have it, effect is *not severe*	4 *Frequently* have it, effect is *severe*
	2 *Ocasionally* have it, effect is *severe*	

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, red or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, need to clear throat
_____ Sore throat, hoarse, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiff or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tired
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggression
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

Happy Health and Wellness

Informed Consent for Intravenous (IV) and Intramuscular (IM) Therapy

I, _____, hereby authorize staff from Happy Health and Wellness to administer intravenous therapy and/or intramuscular shots. I have recounted a complete history of all known allergies that I may have. I understand that this treatment involves inserting a needle and injecting a standardized formula into my veins or muscles. I realize there may be some discomfort at the site of treatment and that it is my responsibility to inform the staff of any burning, pain, or negative reactions that I may be experiencing. During intravenous treatment, it is possible for the injection fluid to leak out of the vein into the surrounding tissue. I understand that although the infiltrated fluid may cause pain, it is not dangerous to my health and my body will absorb the fluid. I realize that during and after my treatment I may experience temporary discomfort at the site of treatment.

Advantages of IV/IM therapy:

- Not affected by stomach or intestinal disease
- Total amount given is available to tissues requiring the constituents
- Force nutrients into the cells by means of a high concentration gradient despite low energy due to illness
- Gives doses of nutrients higher than those possible by mouth without intestinal irritation

Disadvantages of IV/IM therapy:

- Pain, bruising or infection at injection site
- Inflammation of vein used for infusion, phlebitis
- Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death

Alternatives to IV/IM therapy:

- Oral supplementation
- Lifestyle and dietary changes

I understand there is no implied or stated guarantee of success or effectiveness of any specific treatment. I understand that I am free to withdraw my consent and to discontinue participation in these treatments at any time. I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment or there is a $25.00 charge. Also, after missing 3 appointments with no notification, IV privileges may be suspended.

Name (please print):_____

Signed: _____Date:_____

Witnessed By: _____