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Health History Questionnaire

Patient's Name: ____ Date: ____________

Prior PCP: _______________________________ Date of Last Physical: _________________

Personal Health History

Childhood Illnesses: Measles Mumps Rubella Chickenpox Polio

Rheumatic Fever Other: _________________

Immunizations: Tetanus Hepatitis Influenza Pneumonia Chickenpox

MMR Shingles

List any medical problems that you have been diagnosed with in the past:

Stroke		Hepatitis	
Heart Disease		Eating Disorder	
Hypertension		Depression/ Anxiety	
High Cholesterol		Drug Abuse	
Asthma/ Emphysema		Osteoporosis	
Thyroid Disease		Arthritis	
Diabetes		Heartburn/ GERD	
Cancer		Bowel Problems	
Alcoholism		Other:	

Name of preferred Pharmacy & Location: _________________________________

Allergies (include medications, food, and environmental):

Medication/ Allergan:	Reaction:

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Medications (please include Over the Counter Medications and Vitamins):

Name of Drug:	Strength:	Frequency Taken:

Past Surgeries:

Year:	Procedure/ Reason	Doctor:

Family Health History:

	Age:	Health Issues:		Age:	Health Issues:
Father:			M. Grandfather		
Mother:			M. Grandmother		
Sibling:			P. Grandfather		
Sibling:			P. Grandmother		

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Health Habits and Personal History

Exams:

Colonoscopy? ______________________________

Mammogram? _____________________________

PAP? _____________________________________

Bone Density? ______________________________

PSA? ______________________________________

Digital Prostate Exam? ________________________

Do you have a Living Will or Advanced Directive? Y N

Would you like information on the preparation of theses? Y N

Exercise:

	Sedentary	No exercise
	Mild Exercise	Climb stairs, walk 3 blocks, golf
	Occasional Vigorous Exercise	Work or recreation, less than 4x/week for 30 mins.
	Regular Vigorous Exercise	Work or recreation 4x/week for 30 mins.

Alcohol:

Do you drink alcohol? Y N If yes, what kind? _______________________

How many drinks per week? __________________________

Are you concerned about the amount you drink? Y N

Have you considered stopping? Y N

Have you experienced blackouts? Y N

Are you prone to “binge” drinking? Y N

Do you drive after drinking? Y N

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Tobacco:

Do you use tobacco? Y N

If so, what kind? ______________________ How many packs per day? ____________

# of years smoking: ___________________ Year Quit: ________________

Drugs:

Do you currently use recreational street drugs? Y N

Have you ever given yourself street drugs with a needle? Y N

Sex:

Are you sexually active? Y N Do you have sexual concerns? Y N

Is intercourse painful? Y N New partner in the past year? Y N

History of STD's? Y N If so, what types? ______________________

History of sexual or physical abuse? Y N

Personal Safety:

Do you live alone? Y N

Do you have frequent falls? Y N Date of last fall? _________________

Do you have vision or hearing loss? Y N

Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss these issues with your provider? Y N

Women ONLY:

Date of last menstrual period? _________________

Any urinary tract, bladder, or kidney infections within the past year? Y N

Do you have any pain or burning during urination? Y N

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Any blood in your urine? Y N

Any problems with control of urination? Y N

Men ONLY:

Do you usually get up to urinate during the night? Y N

If yes, how many times? _____________________

Do you feel pain or burning during urination? Y N

Any blood in your urine? Y N

Any burning or discharge from penis? Y N

Has the force of urination decrease? Y N

Have you had any kidney, bladder, or prostate infections in the past 12 months? Y N

Do you have problems with emptying your bladder completely? Y N

Any difficulty with erection or ejaculation? Y N

Any testicle pain or swelling? Y N

Any other issues you would like to discuss with the doctor?

____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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Registration Information

Patient Information:

Patient Name: ____ Date of Birth: ______________

Address: ____

City: ___________________________ State: _________________ Zip Code: _______________

S.S. # (Required)____

Marital Status: ____________ Sex: ___________ Race: ________________ [ ] Declined

Ethnicity: ________________ [ ] Declined Language:____________________ [ ] Declined

Primary Phone: ________________________ Secondary Phone: _________________________

Email Address: ____

Preferred Contact Method: (Circle) Home Mobile Work Email

Patient Employer: ___________________________ Occupation: _________________________

Employer Address: ____

Employer Phone: _________________________ Is the patient a full or part-time student? Y N

Emergency Contact: ________________________________ Phone: ______________________

Relationship: ________________________

Insurance Information:

Primary Insurance: ____

Subscriber:_______________________________ Relation to Insured: ____________________

Subscriber ID #: ______________________________ Group #: ___________________________

Subscriber SSN: __________________________________ Date of Birth: ___________________

Employer: _____________________________________ Occupation: _____________________

Secondary Insurance: ____

Subscriber: _______________________________ Relation to Insured: ____________________

Subscriber ID #: ______________________________ Group #: ___________________________

Subscriber SSN: __________________________________ Date of Birth: ___________________

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Employer: ____ Occupation: ____________________

Medical Information Release Form
(HIPAA Release)

Name: ____ Date: _________________

Release of Information (Past Medical Records)

I authorize the release of information including the diagnosis, records, examinations rendered to me, and claim information be released to:

Spouse: ____

Child(ren): ____

Other: ____

Information is not to be released to anyone.

This release of information will remain in effect until terminated in writing.

Messages

Please call: [ ] home [ ] work [ ] mobile

If unable to reach me:

You may leave a detailed message.

Please leave a message asking me to return your call

____

The best time to reach me is _____________________ between (time) ________________

Email reminders will be sent for appointments 1 week prior and the day of your appointment.

Signed: _______________________________________ Date: ________________________

Witness: ______________________________________ Date: ________________________

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Office Policies and Service Agreement

Assignment of Insurance Benefits and Financial Agreement

I hereby authorize Wellness by the Sea to release any information relating to claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered, without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by this signature as thought the undersigned had personally signed the particular claim. I further authorize my insurance company to pay and hereby assign directly Wellness by the Sea all benefits, if any, otherwise payable to me for services rendered to me and/or any dependents. I understand that I am financially responsible for all charges incurred and accept full financial responsibility for the above-named patient's account.

Patient Financial Policy

The financial policies on the following pages outline our mutual responsibilities in this process.

We know this is a lot of information to read and absorb, but we want to make sure you are fully informed about what we need from you, and what you can expect from us, concerning the financial aspects of your care. As always, we are happy to answer any questions you may have and will continue to work with you in order to resolve your account balance in a timely manner.

Patient Demographic and Insurance Information

It is critical that we have correct demographic (personal) information about you and about your health insurance coverage in order to bill accurately for the services provided to you. This information includes:

- Your name, address, and phone number
- The name of your insurance provider, the group and subscriber numbers
- The accurate claims filing address and phone number
- A COPY of your insurance card

At each visit, we will verify your demographic and insurance information, and make any necessary changes. This is to ensure accurate billing information and protect you by confirming that we are providing services to the correct individual. Please understand that our staff will ask for this information and these documents even if you have recently been seen in our office. If you do not provide us with the needed information in a timely manner, you may be responsible for payment for services rendered.

Cancellations and Missed Appointments

While we understand that personal circumstances sometimes make it necessary for you to cancel your appointment, please notify us as soon as you know you will not be able to keep your appointment. Short-notice cancellations and missed appointments or "no-shows" prevent us from offering that time to other patients wishing to be seen. Appointments not cancelled at

least 2 business days in advance, are considered “late” cancellations and a $25.00 charge will be billed directly to you that is not covered by your insurance. A frequent patter of more than 3 “late” cancellations or “no-shows” makes it impossible for the provider to provide appropriate continuity of care and will result in discharge from the practice.

Release of Medical Information

Under Federal HIPPA regulations, we will release information from your medical record to your insurance carrier if required in order to process our claim for services we provided; and to any physician we are referring you to, to provide continuity of care.
If you wish to have us release information from your medical record to other individuals or organizations, the form in the Registration Packet will allow you to provide that information.

Completion of Forms

There may also be times when you request that we complete forms of various types: disability forms, certification forms for handicap license plates or hang tags, tint waiver, FMLA forms etc. If the provider is able to complete a short form during a scheduled office visit, there is no additional charge. However, if the form is long or complicated, will require additional time outside of the scheduled visit to complete, or if you are not being seen for a scheduled office visit, there will be a $10.00 charge, payable in advance, for completion of each form. Please understand that completing these forms requires time by our provider and staff to ensure accuracy. It may also take several days for the forms to be available for pick-up, so please allow sufficient time before the form is needed.

Patients with Insurance Coverage

We participate with many of the major commercial and managed care plans, including various Blue Cross Blue Shield plans, Aetna, Cinga, United Healthcare, and many others. We do also participate with Medicare, and Medicare Advantage plans. However, we do not participate with Cigna Healthspring, and traditional Medicaid, Highmark Health Options, or AmeriHealth Caritas.

Verification of Insurance Coverage

We will verify your insurance coverage at the time of your visit, and again shortly before your next scheduled appointment. If your insurance coverage changes after you schedule your appointment, please notify us as soon as possible, **before** your visit. If we are not able to confirm active coverage, you will be considered “self-pay.”

Referrals

Your insurance plan may require a referral from our office prior to your seeing a specialist. **Under the terms of your coverage, it is your responsibility to obtain the appropriate referral prior to your visit.** If this is the case, please contact our office in a timely manner to

obtain any needed referral prior to your visit. Please note, in most cases insurances will not pay if the referral is obtained **after** services have been rendered.

Non-Covered Services

Our provider follows the current standard of care and appropriate-use guidelines in ordering diagnostic tests or procedures as part of your care. Please be aware that some of the tests or procedures recommended for you by the provider may be determined to be non-covered or may be considered “not medically necessary” based on the benefits provided by your specific insurance plan. You will be financially responsible for the costs of non-covered services and services that your insurance carrier declines to cover.

In the event that a specific service or services may not be covered by your plan, you will be asked to sign an ABN, or Advanced Beneficiary Notice, outlining the services that we have determined may not be covered, and for which you agree to be responsible for payment, **before** we provide those services to you.

Please understand that even for insurance plans with which we participate, covered benefits may vary from one plan to another, and it is impossible for us to know what is covered under every plan.

Copayment and Deductibles

You are responsible for paying your copayment at the time of each office visit. If you are unable to pay your copayment at the time of your visit, you will receive a bill in the mail.

Most commercial and managed care insurance plans also include an annual deductible amount that must be paid by the patient before the plan pays any benefits, and many people now have high-deductible health plans. If you have not met your deductible, your insurance carrier will process the claim towards your deductible, but will not make any payment to us, and **you** will be responsible for payment of the contractual amount approved by your plan.

Non-Payment / Delinquent Accounts

If the self-pay balance on your account is 60 days or more past due, if you do not contact us about your balance or respond to our efforts to contact you, and/or if you do not make agreed-upon payments when we have approved a short-term payment plan, your account balance will be subject to placement for outside collection. In extreme circumstances, an unpaid account balance may result in a patient’s discharge from our care.

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Medication Policy

We strive to ensure our patients are receiving the best medical care we can provide. For this reason, **ALL** prescription refill will **REQUIRE** regular follow up appointments every 3 to 6 months. Repeat "no-shows" or "late" cancellations will result in the denial of the refill.

All refill requests will be addressed during normal business hours and will be responded to within a **72-hour window**. Please do not wait until you are completely out of medication to call for a refill. Medications will on be refilled immediately under emergent circumstances. If you are calling in a prescription refill please leave your name, phone number, medication name and dosage, and pharmacy name and location.

We will not refill medications prescribed by other providers. We **DO NOT** prescribe controlled substances.

New symptoms **REQUIRE** a clinical visit. Our provider will not diagnose and treat over the phone.

I have read and understand the policies and agree to abide by the guidelines.

Patient Signature: ____________________________________ Date: _______________

Witness Signature: ___________________________________ Date: ________________

You will be provided with a signed copy of our policies for your records.

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Authorization to Receive Medical Records/ Information

I authorize the release of my medical records by the organization of physician listed below:

Physician's Name: ____

Physician's Address: ____

Physician's Phone #: ______________________________ Fax #: _______________________

Reason for Records Release: ____

These records are to be sent to Wellness by the Sea at the address listed above. (In Logo)

Patient's Name: ___________________________________ Date of Birth: _______________

Address: ____________________________________ State: __________ Zip: _____________

SSN: ___________________________ Phone #: ____________________________________

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

Entire Medical Record ____________________ Substance & Drug Abuse ______________

Recent 3 years of Records __________________ HIV/AIDS ___________________

Psychological/ Psychiatric _____________________

Other: ____

*I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specific by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure of information and the information may not be protected by federal confidentiality rules.

Signature: _____________________________________ Date: ___________________

Signature: _____________________________________ Date: ___________________

Parent/ Guardian/ Representative Relation to Patient

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Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Wellness by the Sea and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Wellness by the Sea or its affiliates under my cell phone plan.

My text/mobile number is (   ) ______________ [ ] Patient Initials

I know that I am under no obligation to authorize Wellness by the Sea or its affiliates to send me text messages. I may opt-out of receiving these communications at any time by calling (302) 278-0093. Please allow 7-9 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology form Wellness by the Sea and its affiliates to the phone number that I have provided.

Patient Name: ____

Signature: ____

Date: ____________________ Date of Birth: ________________

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electric or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually with-in 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request Confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or healthcare item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information.

- You can ask for a list (accounting) of the times we’ve shared your health information for six year prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.) We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information in the header and on the back page.
- You can file a complaint with the U.S Department of Health and Human Services Office of Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or other involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell. Us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat You:

- We can use your health information and share it with other professionals who are treating you
    - Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
    - Example: We use heath information about you to manage your treatment and services.

Bill for your services:

- We can use and share your health information to bill and get payment from health plans or other entities.
    - Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use your health information? We are allowed to required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html.**

Help with public health and safety issues:

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls

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- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research:

- We can use or share your information for health research

Comply with the law:

- We will share information about you if state of federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:

- We can share health information about you in response to a court or administrative order, or in a response to a subpoena

Patient can access their medical records through our patient portal. Please call the office for your secure log-in information.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.

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- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applies to the following organizations.
Wellness by the Sea
35998 Zion Church Rd.
Frankford, DE 19945
(302)278-0093

Signature: ______________________________ Date: _____________

Witness: _______________________________ Date: ______________