Wellspring Health Access
Patient Registration Form

CONTACT INFORMATION: We need accurate contact information to notify you of any abnormal medical findings. You ***must*** give us some way to contact you. If your phone does not accept blocked numbers, we may not be able to guarantee confidentiality. If this may cause a problem, please discuss this with a staff member. Non-identifying information may be used for program evaluation and research. ***In case of an emergency or life-threatening medical condition, confidentiality may be broken.***

PLEASE PRINT

Legal First Name_____M.I. _____

Legal Last Name _____

Preferred name (if different) _____

Date of Birth:_____Age:_____

Gender: _____

Address:_____Apt. # _____

City_____State_____Zip _____

Preferred Phone #_____

Alternate Phone #_____

Employer:_____

Occupation:_____

Who is here with you today?

_____

Emergency Contact

Name_____

Phone # _____

How did you hear about us?

☐ Internet ☐ Friend/Relative ☐ Yellow Pages

☐ Here Before ☐ NAF ☐ Other

☐ Doctor/Health care Provider _____

Insurance

Do you have Health care coverage? _____

Please answer this question even if you plan to pay cash today. This helps us help you with contraception options and lab tests. Please give card to reception.

Insurance Name: _____

Are you insured by Medicare/ Medicaid? __

Relationship to Insured: _____

Insurance Policy #:_____

Group #: _____

Effective/Print Date: _____

Subscriber's Name: _____

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How would you like us to contact you?

Phone:_____or

Email:_____

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What services do you need today?

_____

I verify that I have answered these questions to the best of my ability. I am financially responsible for any balance due.

PATIENT NAME:_____**SIGNATURE**_____ **DATE:**_____**TIME**_____

Reviewed and discussed by staff:_____ DATE:_____TIME_____

Physician Name:_____Signature:_____ DATE:_____TIME_____

Wellspring Wyoming Health Access
918 E 2nd St
Casper, WY 82601
Phone: 307.224.7852

Health Information Portability and Accountability Act
(HIPAA)

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

Passage of HIPAA occurred to improve the efficiency and effectiveness of the health care system by standardizing the transmission of certain transactions and protecting the privacy and security of the patient's personal health information.

Privacy Rule essentially controls the use and disclosure of protected health information (PHI). The Security Rule protects and safeguards confidentiality of medical information and information that could identify an individual.

Wellspring Health Access understands that your medical information is private and confidential. All Physicians and staff mustadhere to these policies.

As required by law, the HIPAA privacy notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. You can request a written copy of our most current privacy notice.

If you have any questions or would like furthering information about this notice, please contact Wellspring Health Access.

I,_____, acknowledge that I have been offered a copy of Wellspring Health Access' Privacy Notice and I have read that information that is posted in the lobby.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (if minor) Date

Wellspring Health Access Privacy Policy

I have read Wellspring Health Access' privacy policies and patient bill of rights and have been offered a copy.

_____ _____
Signature of Patient/Guardian Date

Wellspring Health Access Advance Directive Policy

I have read Wellspring Health Access' Advance Directive Policy and have been offered a copy.

_____ _____
Signature of Patient/Guardian Date

Patient Consent for Text and Voice Appointment Reminders and Messaging

I authorize Wellspring Health Access to communicate with me via:

☐ Text and/or Voice at _____
☐ Email at _____

I ☐ Do **OR** ☐ Do NOT give my express consent to receive automated text and voice messaging to the number listed above.

Patient/Guardian Name _____
Patient/Guardian Signature _____

Health History

Please print your full name here:_____Date of birth:_____/_____/_____

Do you have any allergies to medications, metals, latex, rubber gloves, tape, shellfish, or antiseptic solutions (iodine/Hibiclens)?

No ☐ Yes ☐ *If yes, list allergy and reaction*_____

Have you ever had a bad reaction to anesthesia or sedation? ☐ NO ☐ YES *explain*:_____

Current medications:_____

SOCIAL HISTORY

No	Yes	
☐	☐	Do you smoke or chew tobacco? If yes, how many/much a day? _____
☐	☐	Do you drink alcohol? If yes, how often and how much?_____
☐	☐	Have you ever used street or IV drugs?_____

CONTRACEPTIVE HISTORY

Are you interested in getting birth control today?

If yes, what: _____

What birth control method are you currently using?_____

What methods have you used in the past?_____

Any problems with your previous methods? ____ no ____ yes If yes, explain:_____

PREGNANCY HISTORY (Please include current pregnancy)

When was the first day of your last menstrual period?_____Are you breastfeeding now? _____

Number of: Pregnancies_____Vaginal deliveries:_____

C-sections: _____ Miscarriages:_____ Abortions: _____Ectopic(tubal): _____

When did your last pregnancy end?_____

Any complications during any past pregnancies? _____

PAST MEDICAL HISTORY Have you **EVER** had any of the following:

No	Yes		No	Yes	
☐	☐	Heart disease or serious heart valve problem	☐	☐	Uterine abnormalities/fibroids
☐	☐	Pulmonary Embolism (PE), heart attack, or stroke	☐	☐	Seizure or epilepsy
☐	☐	Bleeding problems or anemia	☐	☐	Asthma, breathing problems, other lung disease
☐	☐	Serious medical problems, hospitalizations, surgeries: _____	☐	☐	Migraine

REVIEW OF SYSTEMS: Do you ***NOW*** have any of the following:

No	Yes		No	Yes	
☐	☐	**Cardiovascular**: Severe chest pain	☐	☐	**Respiratory:** Difficulty breathing
☐	☐	**Neurological:** Migraine OR severe headache	☐	☐	**Genitourinary:** Severe/persistent pelvic pain
☐	☐	**Endocrine:** Excessive thirst or night sweats	☐	☐	**Genitourinary:** Abnormal discharge or itching
☐	☐	**Lymph:** Painful or swollen glands in your groin	☐	☐	**Genitourinary:** Severe pain with periods
☐	☐	**Gastrointestinal:** nausea or severe abdominal pain	☐	☐	**Mouth:** Bumps or sores in the mouth
☐	☐	**Chest/Breast:** lump, constant pain, or nipple discharge			

Patient signature:_____Date: _____

Wellspring Health Access

Authorization for Release of Information to Family Members/Friends

Patient Name: _____ Date of Birth: _____
(PRINT)

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to friends/family members, you must sign this form. Only individuals listed on this form will be authorized to obtain/inquire about medical and billing information for the patient.

I authorize Wellspring Health Access to release and discuss my medical and/or billing information to the following

individual(s):

1._____Relation to Patient:_____

2. _____Relation to Patient:_____

3. _____Relation to Patient:_____

_____I do not authorize any individuals to inquire/request medical information regarding my treatment at Wellspring Health Access.

PATIENT INFORMATION

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

I have the right to revoke this consent in writing at any time.

SIGNATURE:_____DATE:_____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
AND CANCELLATION OF FUTURE APPOINTMENTS

Patient's Name:_____ Date of Birth: _____

Address:_____ Home Phone: _____

_____ Other Phone: _____

Email: _____

REQUESTING RECORDS FROM: _____

_____

_____

_____

MAIL OR FAX RECORDS TO: Wellspring Health Access
918 E Second St
Casper, WY 82601
Phone: 307.224.7852
Fax: 307.224.7851

Please release medical records pertaining to the following:

_____

Reason for requesting records:

_____

****

I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address. I further authorize that these medical records may be faxed if necessary. I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_____ _____ _____

Patient Signature
(or parent/legal guardian if minor)

Relationship to Patient

Date

Authorization to Bill Insurance

I decline to have my insurance billed for the services received today. If you agree to have your insurance billed, skip to Section 1.

Patients Printed Name:_____Date of appointment: _____
Patients Signature: _____

If you agree to have your insurance billed for the services received, please continue to fill out the information below.

SECTION 1: Patient Information

Last Name:_____First Name_____Middle Initial: _____

DOB:_____SS#:_____ Daytime Phone: (_____)_____

SECTION 2: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name:_____First Name:_____Middle Initial: _____

Address:_____City:_____State:_____Zip: _____

Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

_____ _____

Guarantor's signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Wellspring Health Access to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____
Patient's Signature Date

X_____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority