Wellness for Less™
Medical Center
"Affordable Health Care Without Insurance"

REGISTRATION FORM

PATIENT INFORMATION

(For patients under 18 years of age, responsible parent's information is required)

REASON FOR YOUR VISIT TODAY: _____

Name: _____ **Date**_____

Date of Birth: _____ **Social Security #**:_____

Address: _____City:_____State:_____Zip_____

Phone (____) _____ CELL(____) _____ **Email:** _____

Emergency Contact _____ **Number** _____

HOW DID YOU FIND US? _____

RESPONSIBLE PERSON (IF OTHER THAN PATIENT)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____**Email Address**_____

Employer_____ Work Phone (____) _____

INSURANCE INFORMATION

Name of **PRIMARY INSURED** _____

Relationship to Patient _____ SSN#:_____ DOB_____
Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City _____State:_____ Zip _____

Insurance Company_____ ID#_____ Group #_____
Ins Co Address: _____ Ins Co. Phone: (____) _____

DO YOU HAVE ANY ADDTIONAL INSURANCE? ☐ **Yes** ☐ **No** IF YES, Please inform front office attendant

Signature: _____ DATE_____

Print Name:_____

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Consent for Medical Services

Name (PATIENT) _____ Date of Birth_____

PATIENT and Cindy Steel, nurse practitioner, hereby enter into this agreement for provision of medical services.

1. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.

2. PATIENT acknowledges that Wellness for Less **does not provide** urgent care or emergent care services and that if such care is needed, patient will proceed to NEAREST URGENT CARE. For emergency treatment PATIENT will call 911 or go to nearest hospital emergency.

3. The services provided to the PATIENT may include and is not limited to:

a. Evaluation of patient medical history, lifestyle, laboratory and other test results.
b. I understand that blood testing is strongly recommended prior to undergoing a course of hCG or hormone therapy. Although I may decline this recommendation, I understand that in the event of rare significant side effects of this therapy, it may be more difficult to give optimal treatment in the absence of this laboratory testing information.
c. Physical examination, routine testing (vital signs, spirometry, pulse oximetry) and diagnostic tests.
d. Non and/or minimally invasive treatments (SVN treatment, eye irrigation, wound irrigation and care and medications)
d. Providing medical recommendations or management for disease prevention and healthy aging, which may include advice regarding nutrition and nutritional supplementation, exercise, healthy lifestyle changes, stress management, hormone-balancing and replenishment therapy, and prescription of preventive-aging medical therapy, as indicated by medical history, physical examination and laboratory parameters.

4. The PATIENT agrees to be responsible for the SERVICES. Payment, co-pays and co-deductibles are required at the time of service. The verification of insurance benefits does not guarantee payment for services rendered. The undersigned, patient or guarantor, agrees to payment of the account in accordance with the rates and terms set by Wellness for Less Medical Center. Any balance remaining on the account after insurance benefits are received or denied, becomes the guarantors responsibility. Wellness for Less Medical Center does NOT have any agreements or control over ancillary facility workings or billings (laboratory, radiology, etc.). Any fees or bills that you receive from these facilities are the guarantor's full responsibility.

5. By signing this agreement, the PATIENT understands and consents to medical treatment and permits Wellness for Less Medical Center to submit their claims and health care information for insurance reimbursement as appropriate.

6. I have read and understood the above information. I have given truthful information to the best of my knowledge

_____ _____ _____

Patient/Guarantor Signature **Relationship to Patient** **Date**

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HIPPA PATIENT DISCLOSURE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. With my consent, Wellness for Less (W4L) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to W4L Notice of Privacy Practices for a more complete description of such W4L uses and disclosures.

2. I have the right to review the Notice of Privacy Practices prior to signing this consent. W4L reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wellness for Less Medical Center, HIPPA Officer, at 2530 E Indian School Rd, Phoenix, Arizona 85016.

3. With my consent, W4L may call my home, person documented as emergency contact or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

4. With my consent, W4L may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

5. With my consent, W4L may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that W4L restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

6. By signing this form, I am consenting to W4L use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, W4L may decline to provide treatment to me.

I consent to the release of medical information to _____ limited

to _____ information for the purpose of _____

Pt Initial_____.

_____ _____

PRINT NAME OF PATIENT PRINT NAME OF LEGAL GUARDIAN

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

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ADVANCED DIRECTIVES

Name (PATIENT) _____ Date of Birth_____

Arizona Advance Health Care Directive, protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

A Health Care Agent or Power of Attorney permits the appointment of an adult as Agent. An adult agent makes decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself.

A Living Will lets you discuss your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. Your living will may control or guide your agent's decisions regarding your health care treatment.

If you are interested in learning more about making these choices, you can find forms and further discussion on these sites: azag.gov, azsos.gov, caringinfo.org.

I have received education and information regarding advanced directives and appointing a health care agent.

☐ I DO HAVE ADVANCED DIRECTIVES PREPARED.

☐ I DO HAVE A HEALTH CARE AGENT APPOINTED.

☐ I DO **NOT** HAVE ADVANCED DIRECTIVES OR A HEALTH CARE AGENT.

_____ _____

PRINT NAME OF PATIENT PRINT NAME OF LEGAL GUARDIAN

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**