WCHEALTH

New Patient Demographics

Name:_____ **DOB**:_____

Phone Number:_____ Can we text appointment reminders? YES NO

Email:_____ Can we email appointment reminders? YES NO

Address:_____

Gender:_____ SSN:_____

Current Marital Status:_____

Race: _____ Ethnicity: _____ Preferred language_____

Preferred Pharmacy:_____

Preferred Lab: _____

Insurance Information

Health Insurance Name:_____

Health Insurance#:_____

Policy Holder Name or Guarantor (If patient is a minor):_____

Date of Birth (Policy Holder or Guarantor):_____

Emergency Contact

Emergency Contact Name : _____ Relationship:_____

Emergency Contact #_____

Allowed to discuss Medical/Financial information: _____

Patient Signature_____
Date:_____

Guardian Signature if Patient is a Minor_____
Date:_____

Medical History Questionnaire

Patient Name:_____ DOB:_____

1. Main Reason for Appointment:_____
2. Previous Primary Care Physician:_____
3. (Women only) OBGYN/ Women's Health Physician:_____
4. Do you see any Specialists? If so please ask for an ROI:_____
5. **Allergies**: _____
6. Surgical History _____
   _____

Social History

1. Smoking Status: Current Past Never
   Packs per day:___
2. Alcohol Use: Current Past Never
   Drinks per Day:_____
3. Illicit Drug Use: Current Past Never
   Type:_____

Current Medications

Medication Name	Strength	How often

Patient Medical History

Cardiovascular
___ Congestive Heart Failure
___ Angina(Chest Pain)
___ Arrhythmia
___ High Cholesterol
___ Blood Clots
___ Heart Attack
___ Peripheral Vascular Disease

Hematological
___ Anemia
___ Bleeding Disorder
__ Iron Deficiency

Pulmonary
___ Pulmonary Embolism
___ Pneumonia
__COPD
___ Asthma
___ Sleep Apnea

Infectious Disease
__Hepatitis A,B,or C
__ HIV/AIDS
__ Tuberculosis

Vision
__ Blindness
__ Visual Disturbances

Gastrointestinal
__ Liver Disease
__ IBS(Irritable bowel)
__ HeartBurn
__ Ulcer

Immunology
___Anaphylactic Reaction
___ Latex Allergy

Endocrine
___ Diabetes Type1
___ Diabetes Type 2
___ Thyroid (Hypo or Hyper)

Integumentary
___ Skin Infection
___ Cyst
___ Herpes Simplex

Neurological
__ Seizures
__Nerve Disorder
__ Headaches
__ Parkinson's
__ Tremors
__ Stroke

Psychiatric
__ Bipolar Disorder
__ Depression
__ Anxiety
__ Personality Disorder
__ Schizophrenia
__ Autism

Musculoskeletal
__ Osteoporosis
__ Arthritis
__ Fibromyalgia
__ Arthritis

Nephrology
__ Kidney Failure
__ Kidney Disease

Oncology
__ Cancer

Ear/Nose/Throat
__ Hearing loss

WCHEALTH

Family Medical History

**Check all that apply, Only immediate family members health history (Mother or Father)

Cardiovascular
___ Congestive Heart Failure
___ Angina(Chest Pain)
___ Arrhythmia
___ High Cholesterol
___ Blood Clots
___ Heart Attack
___ Peripheral Vascular Disease

Hematological
___ Anemia
___ Bleeding Disorder
__ Iron Deficiency

Pulmonary
___ Pulmonary Embolism
___ Pneumonia
__COPD
___ Asthma
___ Sleep Apnea

Infectious Disease
__Hepatitis A,B,or C
__ HIV/AIDS
__ Tuberculosis

Vision
__ Blindness
__ Visual Disturbances

Gastrointestinal
__ Liver Disease
__ IBS(Irritable bowel)
__ HeartBurn
__ Ulcer

Immunology
___Anaphylactic Reaction
___ Latex Allergy

Endocrine
___ Diabetes Type1
___ Diabetes Type 2
___ Thyroid (Hypo or Hyper)

Integumentary
___ Skin Infection
___ Cyst
___ Herpes Simplex

Neurological
__ Seizures
__Nerve Disorder
__ Headaches
__ Parkinson's
__ Tremors
__ Stroke

Psychiatric
__ Bipolar Disorder
__ Depression
__ Anxiety
__ Personality Disorder
__ Schizophrenia
__ Autism

Musculoskeletal
__ Osteoporosis
__ Arthritis
__ Fibromyalgia
__ Arthritis

Nephrology
__ Kidney Failure
__ Kidney Disease

Oncology
__ Cancer

Ear/Nose/Throat
__ Hearing loss

CONSENT FOR TREATMENT

I, hereby authorize Well Care Behavioral and Medical Clinic to provide treatment for any services recommended and agreed to for myself or a minor in my care, as a voluntary person, by signing below.

I understand that such care and treatment may consist of an evaluation process, mental health services, case management, medical care as deemed necessary, and, in some instances, medication. If I receive medication, my psychiatrist or treating provider may share information with other physicians about the drugs prescribed and may receive their information about currently prescribed medications. In the event of incapacitation or inability to consent due to medical crisis, I hereby offer my consent to receive medical care that is deemed as life-sustaining or emergent.

Well Care is authorized to administer the treatment/services described above. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against medical advice.

I further understand that I have the continuing right to an explanation of the treatment to be administered, and that I may address complaints about services to the Nevada Bureau of Consumer Affairs, 775- 684-1100, or the Nevada Division of Public and Behavioral Health, Bureau of Healthcare Quality and Compliance at 775-684-1030.

I further understand that my records are confidential under Federal and State law and will not be released to outside individuals or agencies without my expressed written authorization. However, I realize that certain information may be released without my authorization per C.F.R. 45 Part 2, for the purposes of insurance billing, and as described in the Well Care Notice of Privacy Practices.

I have read the above and I agree to accept treatment and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.

_____ _____

Patient Name Legal Guardian Name

_____

Signature (Patient or Legal Guardian) Date

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and Well Care Services. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When we examine, test, diagnose, treat, or refer to you, we will be collecting what the law calls “protected health information"(PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling our office to speak with our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment,or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Patients Name (Printed):_____

Signature of Patient or Guardian: _____

Date: _____

Patient's Rights: Adults

As the patient of a program for treatment of abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1. If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.
2. You have the right to be provided treatment appropriate to your needs.
3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
4. You have the right to be informed of all program services, which may be of benefit to your treatment.
5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.
7. You have the right to be informed of our diagnosis, treatment plan and prognosis.
8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.
9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
10. You have the right to examine your bill for treatment and to receive an explanation of the bill.
11. You have the right to be informed of the program's rules for your conduct at the facility.
12. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal. You have the right to receive respectful and considerate care
13. You have the right to receive continuous care: To be informed of our appointments for treatment ,the names of program staff available for treatment, and of any need for continuing care.
14. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so. You have the right to safe, Healthful and comfortable accommodations.
15. You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.
16. Waiver of any civil or other right protected by law cannot be required as a condition of program services.

17. You have the right to freedom from emotional, physical, intellectual, or sexual harassment o abuse.
18. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.
19. You have the right to grieve actions and decisions of facility staff, which you believe, are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequences as the product of filing a grievance.
20. You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, 4126 Technology Wa*y,* 2nd Floor, Carson City, Nevada 89706. Phone: 1 *775*-684-4190
21. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

Patient Acknowledgement

I have read, understand, and have been provided a copy of the above Patient's Rights.

Patient Signature or Legal Guardian

_____

Date:_____

Patient's Responsibility agreement for Controlled Substance Prescriptions

Controlled substance medications (i.e. Benzodiazepines, Hypnotics (Non-Benzodiazepines), and Stimulants) are very useful for controlling both acute and chronic Anxiety, insomnia and AD*D*/ADHD respectively. They all have a high potential for misuse and are, therefore, closely controlled/monitored by local, state, and federal governments. They are intended to relieve symptoms of the disorders stated above, thus improving quality of life, function and/or ability to work. Because my provider is prescribing controlled substance medications to help manage my symptoms in regards to my diagnosis, I agree to the following conditions:

Treatment Goals:

I understand that the main treatment goal is to reduce my symptoms to a manageable level and improve the quality of my life. In consideration of this goal, and because of the fact that I am being given potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. In addition to healthy habits, I will also attend psychotherapy as recommended by my provider. I must also comply with the treatment plan as prescribed by my provider.

*Patients Responsibility (Please **initial** next to each statement)*

___I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I run out early," I understand that it will not be replaced.

___I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical/Psychiatric care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.

___I will use only one pharmacy for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

___I know that telephone refills are not allowed. Calls or faxes from pharmacies to refill medications will not be authorized.

___I agree to random PILL COUNT to monitor medication usage. I understand that if the provider feels that I am at risk for psychological or physical dependence (addiction); my medications may be tapered off within 7 days. These will be performed during regular office hours. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. À discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for discontinuation of prescribed controlled medication. Patients who fail to show for random pill counts will be immediately terminated from the practice.

___I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.

___I agree to undergo r**andom urine d**rug testing within 24 hours of office visit at the discretion of the provider. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for medication taper to completion

___I will **not** request or accept the same or similar form of controlled medications from any other physician while receiving treatment from this office. I will not give, share or sell my medications to any other person

___I will turn in ALL medication prescriptions within 2 weeks after receiving them. If after 2 weeks the prescription expires, I will **NOT** receive new scripts, I will have to wait until the following month to receive new prescriptions.

Medication Refills

___Will be made only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays. No telephone Refills to pharmacy.

___Will not be made if I "run out early," or "lose a prescription," or "spill or misplace iny medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I anı also responsible for keeping the medications in a secure location as to avoid theft.

___Will not be made an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hours in advance to schedule an appointment for refills.

Risks of Chronic Benzodiazepine Use

___I understand that the long-term advantages and disadvantages of chronic Benzodiazepine use have yet to be scientifically determined. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate. I am aware that tolerance to controlled medications means that I may require more medicine to get the same amount of symptoms relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to medications may force my doctor to choose another form of treatment.

Risk of Chronic Stimulant Use

I understand that the long-term advantages and disadvantages of chronic Stimulant use have yet to be scientifically determined. But research finding suggests the following:

___cardiovascular complications may appear earlier in older adults receiving maintenance amphetamine treatment. Because the way amphetamines work in the body differ between children and adults, evaluation of the potential for adverse effects of chronic treatment of adults is essential and warrants Yearly EKG testing..

___Amphetamines long-term use may pose a risk on the growth of children due to reduced caloric intake in view of the decrease in appetite associated with these drugs.

___Although most adult patients also use amphetamines effectively and safely, occasional case reports indicate that prescription use can produce marked psychological adverse events, including stimulant-induced psychosis and Mania

Risks of Chronic Hypnotic Use

I understand that disadvantages of chronic hypnotic use have been scientifically determined:

___Chronic hypnotic use is strongly associated with insomnia, poor function, and poor quality of life.

___Chronic use of hypnotics may create sleep and performance problems, memory disturbance, driving accidents, and falls.

___There is no persuasive evidence that long-term use of hypnotics produces any benefit. Rather, the risks of chronic hypnotic use outweigh the benefits, which is why I will be prescribed hypnotics temporarily

Risks of Concomitant use of Controlled Substances

___The concurrent use of opioids (Morphine, Oxycodone, Percocet, Tramadol, Hydrocodone, Dilaudid etc.), benzodiazepines (Xanax, Ativan, Clonazepam, Diazepam), Hypnotic (Ambien, Temazepam, Halcion, Lunesta, etc.), alcohol, marijuana and other illicit drugs poses a higher risk of adverse events, overdose, and even death. To improve patient outcomes, ongoing screening for unusual behavior, monitoring of treatment compliance, documentation of medical necessity, and the adjustment of treatment to clinical changes are essential.

Female Patients Only

___I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

ACKNOWLEDGEMENT OF INFORMATION

I have been fully informed by my provider regarding the potential for psychological and physical dependence (addiction of controlled substance medications and risk of chronic use of these medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under my provider's supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

Termination of Care

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice, I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriate legal authorities. I am responsible for any withdrawal syndrome that may occur due to my misuse of the narcotic medications and/or termination of my care. I have read this contract and the same has been explained to me by my provider and the office staff. I fully accept the consequences of violating this agreement.

Patient Name:_____ Date:_____

Patient Signature:_____

Witness:_____

Informed Consent for Telemedicine Services

Patient Name:_____ DOB:_____

Clinician Name: WellCare Behavioral and Medical Clinic

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care clinicians, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient Medical Records & Medical Images
- Live two-way audio and video.
- Output data from medical devices, sound, and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Responsibility for patient care remains with the patient's local clinician, as does the patient's medical record.

Expected Benefits:

Improved access to medical care by enabling a patient to remain in a local health care setting. More efficient medical evaluation and management. Obtaining the expertise of a specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to, the following:

- In rare cases, the consultant may judge that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient.
- Delays in medical evaluation and treatment could occur due to limitations or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I indicate that I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no patient identifiable information obtained in the use of telemedicine will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand the alternatives to telemedicine consultation as they have been explained to me, and in

choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners involved in my care who may be located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. I understand that individuals other than my health care provider and consulting health care provider may be present and that they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence.

I have read and understand the information provided above regarding telemedicine, have discussed it with my clinician or such assistants as may be designated the clinician. I hereby authorize **Well Care Medical and Behavioral Health Services** to use telemedicine in the course of my diagnosis and treatment.

Signature of patient:_____

Witness Signature:_____

I have been offered a copy of this consent form(Patient's initial)_____

Date:_____