ISLAND HEALTH & WELLNESS CENTER

Date:

Month Day Year

Name:

First Name Last Name

Nickname / AKA:

Date of Birth:

Month Day Year

Cell Phone:

Area Code Phone Number

Home Phone:

Area Code Phone Number

Mailing Address:

Street Address

City

State

Zip Code

Physical Address:

Street Address

City

State / Province

Postal / Zip Code

Email:

example@example.com

Last 4 Digits of SS#:

May we send an email?

- Yes
- No

May we leave a voice message?

- Yes
- No

May we send a text message?

- Yes
- No

Occupation & Employer:

Emergency Contact Phone Number:

Area Code Phone Number

Emergency Contact Name:

First Name Last Name

Emergency Contact Relationship to Patient:

Do you currently have health insurance?

- ◯ Yes
- ◯ No

If Yes, does it cover mental health?

- ◯ Yes
- ◯ No

Do you currently have Medicare / Medicaid? (If yes, please sign waiver regarding reimbursement)

- ◯ Yes
- ◯ No

Do you have ALLERGIES?

- ◯ Yes
- ◯ No

If YES, please list any known allergies:

Signature:

Date

Month Day Year

ACKNOWLEDGEMENT OF RECEIVING PRIVACY POLICY AND AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have received a copy of the Privacy Policy of Island Health & Wellness Center and that I authorize Island Health & Wellness Center to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations, as described in the Privacy Policy.

Signature:

Date

Month Day Year

GENERAL CONSENT FOR TREATMENT

I request and authorize health care services by my provider and his/her designee(s), at Island Health & Wellness Center, as my provider may deem advisable and in my best interest. This may include routine diagnostic, medication prescription/administration and laboratory procedures. I understand that my provider and designee(s)will inform me of the services being provided and discuss the reason/rationale and need for what is being provided. I understand that I have the right to refuse services and/or treatment, even against medical advice. I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing mean opportunity to accept or decline that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment.

Signature:

Date

Month Day Year