San Juan
Health and Wellness Center

Patient Information Form

Blue or black ink only

Patient Information

Name: _____ Date of Birth: _____

SSN#: _____ Sex: ___ M ___ F single married divorced widowed separated

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Responsible Party Information (must be completed for all minor patients)

Name: _____ Date of Birth: _____

SSN#: _____ Sex: ___ M ___ F single married divorced widowed separated

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship to patient: _____

Emergency Contact (other than responsible party or self)

Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information:

Please note: To bill your insurance and/or to obtain prior authorizations for services we must have a copy of the insurance card and **COMPLETE** policy holder information. If this information is not provided, patient will be considered a self-pay. All payments are due at the time of service i.e., any balance, co-pays, co-ins, or deductibles.

Primary Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Financial Agreement:

As a patient, it is important that you understand the benefits and limitations of your insurance coverage. Before your appointment, we will verify your basic insurance coverage as the first step. There may be additional research you want to do to ensure you understand your financial responsibility under your plan.

Please read the following for additional information regarding what you may be responsible for:

Information Security:

We recognize that many patients are concerned about the sensitive nature of their information we collect, and we assure you that we take every precaution to keep your personal information secure and use this information only to assist us in providing the services, filing claims and for identification/communication purposes as it relates to healthcare operations. We are required to obtain complete demographic information which includes your social security number to support billing for the services. Refusal to provide this information may constitute a refusal of service.

Financial Responsibility:

As a courtesy, we will send statements each month for any balance that you may owe for services. You are responsible for any balance due regardless of insurance coverage. If at any point an account

becomes past due, we reserve the right to collect on these balances prior to scheduling any future appointments. Collection of past due amounts may involve a collection agency.

We reserve the right to limit, reschedule, or refuse treatment to anyone who cannot pay at the time of service.

Acknowledgement:

By signing this document, I hereby:

- **Authorize the Assignment of Benefits:** Assign all medical benefits under my coverage to San Juan Health and Wellness Center for services provided to me. Furthermore, my signature authorizes and directs my insurance carrier(s), including Medicare, Medicaid, private insurance, and any other health/medical plan to issue payment directly to us for services rendered.
- **Agree to my Financial Responsibility:** I acknowledge and understand that my insurance co-payments are due at time of service, **and** I am responsible for any amounts that are not covered by my insurance, which may include co-insurance, deductibles, or claims denied due to contracting.
- I have received, understand, and agree to abide by the above as it relates to my financial obligations as a patient.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Patient Name (please print): _____

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I have been given the opportunity to review a copy of the Notice of Privacy Practices of San Juan Health and Wellness Center effective January 1, 2018. Copy of the Privacy Practices are available at the front desk.

Patient or Legal Guardian Signature: _____

Date: _____

No Show/Late Cancellation Policy

The appointment times we have to offer you are limited and in high demand. Due to this, San Juan Health and Wellness Center has established the following no show/late cancellation policy:

- Appointments that are cancelled or rescheduled with less than 24-hour notice will be considered a **late cancellation**.
- If you are unable to keep your appointment and do not notify the office, you will be marked a **no show**.
- If you arrive more than **5 minutes** late to your scheduled appointment time, you will be marked a **no show,** and you will be asked to reschedule your appointment to the providers next available.
- There will be a **$75.00** no show/late cancellation fee and must be paid before your next appointment can be scheduled. **The no show/late cancellation fee WILL NOT be billed to your insurance.**
- I understand that if I have three (3) or more **late cancellations** and/or **no shows** withing a six-month period **with any provider** in the office, San Juan Health and Wellness Center reserves the right to terminate the provider patient relationship and discharge me from the practice.

By signing below, I acknowledge that I have read, understood, and agree to all the above statements.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Patient Name (if not the signer): _____

I understand if myself or anyone associated with me mistreat, threaten, or abuse either physically and/or verbally **ANY** staff at San Juan Health and Wellness Center I will be asked to leave, and my behavior may result in being discharged from San Juan Health and Wellness Center. I will treat those giving me care with dignity and respect.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Patient Name (if not the signer): _____

Informed Consent for Treatment

I _____ (print name of patient), agree and consent to participate in behavioral health care services offered and provided at San Juan Health and Wellness Center. I understand that I am consenting and agreeing to San Juan Health and Wellness Center to provide a service from a licensed provider who is qualified to provide, within the scope of the provider's license, certification, and training.

Please note the following about treatment:

Our staff will depend on statements made by the patient and/or guardian, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services may be provided with telemedicine equipment and involve interaction with providers who are not physically present in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, or saved in any way. However, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorize to initiate and consent to treatment on behalf of this individual.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Patient Name (if not the signer): _____

Current Medication: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Medication	Dose	Times Per Day	Reason	Prescribed By

Additional Prescription Coverage (if different from primary insurance):

RX Insurance Name: _____ Policy #: _____

Group #: _____ Phone #: _____

To obtain prior authorizations for medication we must have a copy of the prescription coverage card on file. If this information is not provided it may delay the process of getting the approval for your medication.

Preferred Pharmacy:

Name: _____ Phone: _____

Address: _____

Primary Care Provider:

Name: _____ Phone: _____

Medication allergies and reactions:

_____

_____

_____

_____

Medication Treatment Agreement

This agreement refers to medicines prescribed by the providers at San Juan Health and Wellness Center.

The risks, benefits, alternatives, and side effects of your medication will be explained to you during your scheduled appointment.

- I will take all medication as prescribed by my provider.
- I **will not** change how I take these medicines without first talking to my provider.
- I understand that if my provider or any staff at San Juan Health and Wellness Center feel I am misusing (i.e., not taking medication as prescribed, taking more than prescribed, running out of medication early) any of the prescribed medication(s), it can result in **immediate termination** from the clinic.
- I understand that changes in prescriptions will only be made during scheduled appointments and not by phone, which includes after clinic hours, weekends, or holidays.
- I understand that refills will not be made as an "emergency". A minimum of **72 business hours** notice is needed for prescription refill requests to be processed. Refill requests should be made by contacting your pharmacy.
- If I am unable to get my prescription from my pharmacy for any reason, other than a prior authorization, I will notify the providers medical assistant(s) immediately.
- I understand that the medication(s) should help me function better. If my activity level or general function get worse, my provider may change or stop the medication.
- I agree that my provider may contact other health care providers or pharmacists involved in my care to discuss my progress.
- If I request a refill while my provider is out of the clinic, refills will be made once they return to the clinic.
- (Females only) If I become or plan to become pregnant while taking any medication prescribed to me from a provider at San Juan Health and Wellness Center, I will notify my provider immediately.

Patient or Legal Guardian Signature: _____

Printed Name: _____ Date: _____

Patient Name (if not the signer): _____