nh-hormones.com (425) 806-4600

Wellness Consult Patient Registration

Name:_____ Birthdate:_____/_____/_____
(LAST) (FIRST) (MI)
Home Address:_____City:_____ State:_____ Zip:_____

Preferred Phone #: (_____)_____ EMAIL:_____

Emergency Contact Person: Name: _____ Phone # (_____)_____

Patient Responsibility Acknowledgement (PLEASE READ CAREFULLY):

By signing this form, I acknowledge and agree that I am financially responsible for all charges for any and all services rendered, due at the time scheduling and/or service. This may include any labs ordered, deemed necessary by the provider. The current clinic service list and fee schedule is available to view on the clinic website: nh-hormones.com. Fees and available services may be updated from time to time.

I understand that in order to offer clients the lowest possible out-of-pocket prices, Wellness Consult Services and associated laboratory test fees are not eligible for reimbursement by insurance providers, nor can these lab orders be submitted with my insurance information. Payment for Wellness Consult Services and associated laboratory tests must be paid for in full at the time of scheduling and/or service.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss an appointment without adequate notice, you will be required to pay a $50 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $50 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable and we may dismiss you as a patient for future visits.

Patient Signature: _____ Date: _____

Please return completed pages 1-5 via secure fax: (855) 615-2852 or (425) 806-4622
OR email to: nhhormones@protonmail.com **OR** you can request from us a secure **Dropbox** link to upload your forms, just give us a call or email. **If you would prefer to mail your forms back to us via USPS, please send to:** P.O. Box 1732, Snohomish, WA 98291-1732

Wellness Consult Intake Forms

Name: _____ **Age:** _____ **DOB:** _____

What are your primary Health & Wellness goals?

_____

_____

_____

Rate your current overall health status: *Excellent* *Good* *Fair* *Poor*

Current Medications (Include Strength, dosage, and frequency):

Herbal Supplements and Vitamins (Include Strength, dosage, and frequency):

ALLERGIES (to medications or food):

_____

Medical History

Where do you receive your medical care? _____

Last time you were seen for medical care? _____

*We do encourage our clients to have an established Primary Care Provider or Clinic for potential referral purposes

Significant p**ersonal** medical history / diagnoses (with dates if possible):

_____

_____

Significant **family** medical history:

_____

_____

Nutrition, Habits & Exercise

Nicotine Usage (Circle one): *Never* *Current* *Former*

Alcohol Usage **per week** (Circle one): *None* *1-2* *3-5* *6+*

Caffeinated beverage usage **per day** (Circle one): *None* *1-2* *3-5* *6+*

Are you currently following a specific diet plan, Explain? _____

Dietary restrictions/Known food sensitivities: _____

Do you eat a well-balanced diet? If no, where do you feel you could make improvements?

_____

Exercise frequency per week? (Circle one): *None* *1-3* *4-6* *7-9* *10+*

Type and length of Exercise? _____

Please Note: This appointment will not focus on weight loss. However, creating a lifestyle of good nutrition and healthy living is a very important aspect of healthy weight management.

Is daily fatigue currently a problem for you? *Yes* *No*

Have your energy levels changed over the last 6-12 months? *Yes* *No*

If yes, please explain: _____

Mood & Sleep

Current stressors:_____

_____

Are you currently experiencing changes in your sleep habits? *Yes* *No*

If YES, please explain: _____

How many hours of sleep do you get each night, on average? *10+* *7-9* *5-6* *Less than 5*

Are you currently having any mood related symptoms? (Circle One) *Yes* *No*

If YES, please explain:

_____

_____

Please rate the overall severity of your current mood related symptoms: *Mild* *Moderate* *Severe*

Have you ever had a prior mental health diagnosis? _____

If YES, please explain: _____

Additional Questions:

Menstrual Status: Are you still having periods? *Yes* *No*

Do you have any current concerns about your menstrual cycle? *Yes* *No*

If YES, please explain: _____

Do you have concerns about your Hormones? Yes No

If YES, please explain: _____

Any additional Information that you feel would be important when discussing your personal health and wellness goals:

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Do you give NHH permission to leave a **voicemail** regarding appointment reminders and/or lab results?

YES: ☐ Preferred Phone Number: (_____)_____

NO: ☐ Please **DO NOT** leave voicemail messages

Do you give NHH permission to send **emails and/or text messages** to you regarding appointment reminders, and clinic information, updates, and/or clinic promotions?

YES: ☐

NO: ☐ Please **DO NOT** email or text this information

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's written consent. Because of this, we must have permission from you to share any medical related information. If you would like to give us permission to share any of your Personal Health Information (PHI) please list their name(s) below:

Name:_____ Phone #:_____ Relationship to Patient:_____

Name:_____ Phone #:_____ Relationship to Patient:_____

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke any or all portions of this consent at any time, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. NHH provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I acknowledge that New Horizon Hormones has provided me with a copy of Notice of Privacy Practices which describes in more detail how your Personal Health Information may be used and disclosed, and how you may access your information.

Printed Name: _____ Date of Birth: ____/____/_____

Patient Signature :_____ Today's Date: _____

Notice of Privacy Practices (NPP)

New Horizon Hormones

Lauren Schweizer, ARNP

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please Review it carefully.

I. UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our clinic, a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment plan for future health care, and financial information. This record is sometimes referred to as your "medical chart" or "medical record".

This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Our clinic to obtain payment for services we provide to you, such as from insurance, or you; and
- Our clinic to measure the quality of care provided to you.

We are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as otherwise stated in this notice.

II. HOW WE WILL USE AND GIVE OUT YOUR HEALTH INFORMATION

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our clinic. **For example:**

- We will give your health information to health care professionals not on our staff, such as doctors and/or hospital staff who are helping to care for you such as your Primary Care Provider;
- We may send a bill to your health insurance plan, or to you; and
- Our clinic may use your medical records to review our performance and make sure you receive quality health care.

b. Other Uses and Disclosures Allowed or Required by Law

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your healthcare (such as to pick up medicine or help with follow-up care);
- To government agencies that oversee our clinic (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- When ordered by a court or judge;
- To workers' compensation programs when your health problem is from a work-related injury;
- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);

- ➢ To avoid a serious threat to the health or safety to yourself or others;
- ➢ To contact you about new treatments or medicines that may help you;
- ➢ To business associates of the clinic that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law); and
- ➢ For any other purpose required or allowed by law.

c. Other Uses and Disclosures Requiring Your Written Permission:

Except as stated above, we will use or give out your health information only after getting your written permission on an authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- ➢ Request limits on uses of your health information
- ➢ Receive confidential communications of your health information
- ➢ Inspect and copy your health information per WAC 246-08-400
- ➢ Request a change to your health information
- ➢ Receive a record of how we have used and given out your health information
- ➢ Obtain a copy of this Notice of Privacy Practices

IV. QUESTIONS, CONCERNS, AND CHANGES TO THIS NOTICE:

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact the Practice Manager at New Horizon Hormones - Phone: 425-806-4600.

If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, submit it to the Practice Manager at:
P.O. Box 1732, Snohomish, WA 98291-1732. All complaints must be submitted in writing.
We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future, such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at our clinic and on our website.