WILLOW WELLNESS CENTER LLC

Carroll, Ohio 43112
(ph): (740) 756-4800
(fx): (740) 756-4816
email: willowwellness4773@gmail.com

PATIENT DEMOGRAPHIC FORM

(TO BE UPDATED ANNUALLY OR WITH ANY CHANGES)

Patient Name:_____ Date of Birth:_____
First MI Last

Social Security #: _____-_____-_____ Marital Status: S M W D

Mailing Address:_____ City/State:_____ Zip:_____

Email:_____

Would you like to sign up for access to your medical records via the internet? Yes No

Home Phone #: (_____) _____-_____ Cell Phone #: (_____) _____-_____

Employer: _____ Work Phone #: (_____) _____-_____

Referring Physician:_____ Practice:_____

Spouse Name:_____ Date of Birth:_____

Employer: _____ Work Phone #: (_____) _____-_____

Emergency Contact & Relationship:_____ Phone #: (_____) _____-_____

Please list individual(s) we are authorized to speak with regarding your care/account:

_____

INSURANCE INFORMATION: Please provide insurance card for us to copy. Even though we bill Medicare and Medicare Advantage Plans, we will be happy to provide you with a claim form to send to your insurance company.

Insurance Co.:_____ Policy Holder:_____

Policyholder's Date of Birth:_____ Social Security #: _____-_____-_____

Member ID #:_____ Group #:_____

Patient/Parent Signature:_____ Date:_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices provided by Willow Wellness Center.

My signature is only a confirmation that Willow Wellness Center has given me the opportunity to review Privacy Practices as mandated by law.

Patient Name (Print)_____

Signature:_____ Date:_____

Relationship to Patient: [ ] Self [ ] Parent/Guardian [ ] Personal Representative

**********OFFICE USE ONLY**********

Patient unable to sign. Reason:_____

Staff Initials:_____ Date:_____

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Willow Wellness Center Cancellation/No Show Policy for Doctor Appointments

We understand that situations may arise where you may have to miss an appointment due to an emergency or unforeseen problem. However, when you do not call to cancel your appointment, another patient may be prevented from getting the care that they need due to a seemingly full doctor's schedule. As a courtesy to our practice and our other patients, we ask that you call us at (740) 756-4800 to reschedule your appointment as soon as you realize that you are not going to be able to keep your scheduled appointment time.

****Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $25 fee. This fee will not be covered by your insurance.****

_____ _____

Patient's Name (please print) Patient/Guardian's Signature

____/____/_____

Date

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PAYMENT POLICY

Willow Wellness Center is committed to providing the best possible care and service. We work to keep costs low, and we have chosen not to participate in commercial health care networks, Medicaid, or Workers Compensation.

PATIENTS WITH MEDICARE: We accept Medicare and bill for covered services. Medicare patients are required to pay for non-covered services at the time of service. Medicare Advantage policyholders (MediGold, Humana Gold, etc.) are also required to pay their co-pay at the time of service.

PATIENTS WITH INSURANCE: We are not contracted with any insurance company. Patients are to pay at the time of service and a claim form will be given that contains all the necessary information for your insurance company to process for benefit determination. Your insurance is a contract between you and the insurance company.

PATIENTS WITHOUT INSURANCE: Patients are to pay at the time of service.

PATIENTS WITH MEDICAID: We will not bill Medicaid for covered services. You will be responsible for payment of these services.

The first office visit will be between $120.00 and $205.00 and includes the physical, history, decision-making, and recommendations. Lab work, vitamins, supplements, and therapies are extra.

We accept cash, check, Visa, MasterCard, and Discover.

I have read this policy completely and I agree to abide by the terms. I understand and agree that I am ultimately responsible for paying for services rendered. Further, I understand non-payment of account in the terms specified by Willow Wellness Center may result in my dismissal from care. If I dicontinue care, I understand that I am responsible for payment of any balance on my account in the terms specified by Willow Wellness Center.

Signature:_____ Date:_____

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CONSENT FOR ALTERNATIVE TREATMENT

I,_____, am aware that the natural non-pharmaceutical means by which my physician may recommend to treat me may not be curative for my condition. I am making a personal choice to accept these modalities of treatment based on my own belief that their benefits outweight their risks.

_____ _____

Signature of patient/parent Date

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PAST MEDICAL HISTORY

Major health events, hospitilizations and surgeries (please include year):

_____

_____

_____

_____

_____

Allergies to medication, chemicals, seasonal allergies (please include type and severity of reaction):

_____

_____

_____

_____

_____

Ongoing medical problems:

_____

_____

_____

_____

_____

Family Medical History:

Mother: Deceased? _____ Year/Age: _____

_____

Father: Deceased? _____ Year/Age: _____

_____

Siblings: Deceased? _____ Year/Age: _____

_____

Continued on next page...

Preventive care: (Colonoscopy, Pap smear, mammogram, prostate check, etc.) Please include year of last test.

_____

_____

_____

Social History:

[ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED

• Do you smoke? [ ] YES [ ] NO If **YES**, how many packs per day and for how long?_____

If **NO**, have you ever?_____

• Do you drink alcohol? [ ] YES [ ] NO If **YES**, how many drinks per week?_____

• Do you have children? [ ] YES [ ] NO If **YES**, how many?_____ Ages:_____

• Work: [ ] Full-time [ ] Part-time [ ] Retired [ ] Disabled [ ] Do not work

High School Graduate: [ ] YES [ ] NO College Graduate: [ ] YES [ ] NO

Nutritional History: (What is your diet like? Do you have food allergies?)

_____

_____

_____

_____

_____

Developmental History: (List any developmental delays i.e. speaking, walking, etc.)

_____

_____

_____

_____

_____

Is there anything else you would like for the doctor to know regarding your medical history?

_____

_____

_____

_____

MEDICATION LIST

Please list all medications and supplements you are currently taking, including strength of medication and how often.

Medication/Supplement	Strength	Frequency