NEW PATIENT INFORMATION AND CONSENTS

Name:			Date of Birth:
Mailing Address:	City:	State:	Zip Code:
Cell Phone:	Home Phone:		Work Phone:
To Enroll in the Patient Portal Email Address:			SSN:

Primary Insurance:	ID#:	Group #:
Policy Holder's Name:	Relation to patient:	Policy Holder's Date of birth:
Responsible Party: *(If patient is a minor)*	Relation to patient:	Phone #:
Address: City:	State:	Zip Code:

Previous or Current PCP Name:	PCP Phone #:
Pharmacy:	Pharmacy Phone #:

Race:							Ethnicity:		
		American Indian or Alaska Native		Asian		Black or African American			Hispanic/Latino
		Pacific Islander		White		Decline to specify			Not Hispanic/Latino

Emergency Contact:	Relation to Patient	Phone #:

THE FOLLOWING CONSENTS REMAIN IN EFFECT UNTIL REVOKED IN WRITING

Authorization of Benefits to Provider: I understand that I am financially responsible for **all charges** incurred with **ANERES HEALTHCARE & WELLNESS CENTER**,' I hereby assign and relinquish my interest in and title to my insurance benefits to ANERES HEALTHCARE & WELLNESS CENTER for all services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP): I acknowledge that I have received a copy of the Notice of Privacy Practices for this facility, and I understand that I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities, and general healthcare operations.

Permit for Diagnosis and Treatment: I voluntarily authorize and consent to the examinations, tests, procedures, and routine medical treatment ordered and performed by ANERES HEALTHCARE & WELLNESS CENTER'S physician, physician's assistant, nurse practitioner, or medical assistant.

PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING:		
I consent to receive **email/text/voice mail** messages and appointment reminders.	YES	NO
I understand patient privacy laws apply to **telehealth/virtual visits**. I consent to receive services via telehealth appointments, when applicable.	YES	NO
I authorize Aneres Healthcare & Wellness Center to take and/or use **photographs/video recordings** for identity verification and medical care/training.	YES	NO

_______________________________ Signature of Patient or Authorized Representative

_______________________________ Relationship to Patient

Date______/_______/20_______

Aneres
HEALTH & WELLNESS

PATIENT HISTORY

Date:___________________

Name:	Date of Birth:

CHECK ALL THAT APPLY:

	Minor Child		Single		Married		Divorced		Widowed		College Student		Employed- Occupation:____________________		Unemployed

PLEASE INDICATE SEXUAL ORIENTATION AND GENDER IDENTITY, OR MARK ☐ CHOOSE NOT TO DISCLOSE.

	Male		Female		Transgender Male		Transgender Female		Genderqueer		Straight		Gay		Bisexual		Other____________________

PLEASE MARK IF YOU HAVE, OR HAVE HAD, ANY OF THESE CONDITIONS, SYMPTOMS, PROBLEMS, OR MARK NONE.

MEDICAL HISTORY ☐ NONE

Are your immunizations up to date? **Yes / No**

Acne / Skin Problems	Bladder Infection / UTI	Heart Disease	Thyroid Problems	Stomach / Intestinal Problems
Asthma / Lung Disease	Sexually Transmitted Disease	High Blood Pressure	Vision Problems	Scoliosis / Back Problems
ADHD / Autism	Headaches / Migraines	Stroke	Hearing Problems	Joint / Mobility Problems
Liver Disease	Seizures / Epilepsy	Heart Attack	Sinus Problems	Pregnancy Problems
Hepatitis	Cancer	Diabetes	Anemia	Sleep Problems / Apnea

Please list other health conditions or concerns:

SOCIAL & BEHAVIORAL HISTORY ☐ NONE

Low Self-Esteem	Mood Swings	Physical / Emotional Abuse	Family Stressors	Drug / Alcohol Abuse
Attempted Suicide	Eating Disorder	Learning Problems	Drink Alcohol: Frequency?	
Anxiety / Depression	Mental Illness	Smoke/ Tobacco: Type____________________ Frequency:____________________		

Are there any problems at home you would like to discuss with your provider? **Yes / No** Are you concerned about your safety at home? **Yes / No**

SURGERIES / HOSPITALIZATIONS ☐ NONE

Age	Reason	Hospital

CURRENT MEDICATIONS ☐ NONE

Prescription / Vitamin / Supplement / Over-the-Counter Medication	Strength / Dose	Frequency Taken

ALLERGIES/ DRUG INTOLERANCES ☐ NONE

Allergy / Intolerance	Type	Reaction
	Mild / Moderate / Severe	
	Mild / Moderate / Severe	
	Mild / Moderate / Severe	

FAMILY HISTORY

Please mark if anyone in your family currently has, or has ever had any of the following: ☐ NONE

	Cancer	Diabetes	High Blood Pressure	Stroke	Heart Attack	Thyroid Problems	Drug/Alcohol Abuse	Learning Problems	Mental Illness	Other, list:
MOTHER										
FATHER										
SIBLING(S)										
OTHER: _______________										

FOR FEMALES ONLY

Last Menstrual Cycle: / /	If Hysterectomy: ☐ Complete	☐ Partial - Ovaries Remaining:_____Left _____Right
Last PAP: / /	If abnormal, please explain:	
Last Mammogram: / /	If abnormal, please explain:	

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Permission to disclose your health information to designated individual(s).

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI).

Your written authorization is required before sharing your health information with your spouse, relatives, or employers, etc.

Please CHOOSE AND COMPLETE one of the following disclosure statement options:

OPTION 1:

I, ____, authorize the following person(s) to receive
(Print Name)
protected health information including, but not limited to: **appointments, procedures, test results, and billing**. I understand that this authorization will be in effect with Aneres Healthcare & Wellness Center, until I submit a written request to remove them from this authorized list.

Name	Phone #	Relationship

OR

OPTION 2:

I ____________________________________**DO NOT** authorize individuals, such as family members
(Print Name)
or employers, to receive my protected health information.

____ ____________________ ________________
Signature of Patient or Authorized Representative **Relation to Patient** **Date**

APPOINTMENT CANCELLATION / NO SHOW POLICY

Effective Janurary 1, 2023 established patients will be charged a fee for failure to arrive without notice or cancel their appointment within 24 hours as follows:

1st occurrence: **$25.00** fee
2nd occurrence and beyond: $**45.00** fee
Repetitive failures to attend or cancel appointments without proper notice may result in termination of the patient and provider relationship.

"No show/cancellation" fees are **due at the time of the patient's next office visit.**

Patients are encouraged to utilize the patient portal to cancel or reschedule an appointment.

We understand there may be times when an unforseen emergency occurs and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the "No Show" fee. Please leave us a message if you reach our office and the lines are busy or it is after regular business hours.

Aneres Healthcare, LLC and Aneres Wellness, PLLC 832-307-7106

I have read and understood the "Appointment Cancellation/No Show Policy" and agree to it's terms.

______________________________________	______________________________________
Siganture of (Patient/Guardian)	Relationship to patient
______________________________________	______________________________________
Printed Name	Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this disclosure.

USES & DISCLOSURES:

The following categories describe examples of how we may we use and disclose your health information:

- **For Treatment:** We may disclose health information about you to doctors, nurses, technicians, medical students, or other clinic or hospital personnel who are involved in taking care of you at our facility.
- **For Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer.
- **For Health Care Operations:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

- To business associates we have contracted with to perform the agreed upon service and billing for it; To remind you that you have an appointment for medical care; To assess your satisfaction with our services; To tell you about possible treatment alternatives; To tell you about health-related benefits or services; To inform Funeral directors consistent with applicable law; For population based activities relating to improving health or reducing healthcare costs; and For conducting training programs or reviewing competence of healthcare professionals.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to; Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Military Command Authorities, Coroners, and Health Oversight Agencies.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Patient Copy

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner that compiled it, you have the right to:

- Inspect and copy, request an amendment, request an accounting of disclosures, request restrictions, request confidential communications, and to receive a full copy of this notice.
- To exercise any of your rights, please submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a **written complaint** with this facility. You may also file a **written complaint** with the Secretary of the Department of Health and Human Services.

If you have any questions about this notice, please contact the Health Center's Manager at (832) 307-7106.