# Established Client Update Form

Today's Date: _____

## Client Information

Last Name: _____ First: _____ MI: _____

☐ Mr. ☐ Miss. ☐ Mrs. ☐ Ms. Is this your legal name? ☐ Yes ☐ No If not, what is? _____

Former Name: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Sex: ☐ M ☐ F DOB: _____ Age: _____

Street Address: _____

PO Box: _____ City: _____ State : _____ Zip: _____

Email Address: _____

SSN#: _____ Primary Phone: _____ 2nd Phone: _____

Employer: _____ Employer Phone: _____

## Insurance Information

Primary Insurance Company: _____ Phone: _____

Address: _____

City: _____ State : _____ Zip: _____

Policy # _____ Group# _____ Cardholder's Name: _____ DOB: _____

Secondary Insurance Company: _____ Phone: _____

Address: _____

City: _____ State : _____ Zip: _____

Policy # _____ Group# _____ Cardholder's Name: _____ DOB: _____

## Updates to Medical Information

Current Prescriptions: _____ Surgeries / Hospitalizations: _____

Diagnosis since last time paperwork was completed: _____

Who is your primary care physician? _____

## In Case of Emergency Call

Name _____ Relation: _____ Phone: _____
(Not Living at Same Address)

## Acknowledgement & Patient Notice of our Privacy Practice Form

The above information is true to the best of my knowledge. I understand that I am financially responsible for my balance on any charges incurred. I authorize WellQuest to release any information required to process my medical claims. In the event that I incur charges that are filed with my health insurance, I authorize my insurance benefits be paid directly to the physician.

I have received a copy of the "Patient Notice of our Privacy Practices" from WellQuest Medical & Wellness and Northwest Primary Care Physicians, PA.

Client / Guardian Name: _____ Relationship: _____
(Please Print)

Client / Guardian Signature: _____ Date: _____

WellQuest



WellQuest Medical & Wellness
3400 Southeast Macy Road #18
Bentonville, Arkansas 72712
P: 479-845-0880 F: 479-845-0887

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## Medications Policy

WellQuest Medical & Wellness is currently **not** accepting new clients that require chronic pain management. If you are currently on any controlled substance on a routine basis such as those listed below, we are unable to be your primary care physician.

Controlled substances are listed as Schedule II, III, IV by the Food and Drug Administration.

- This list includes but is not limited to pain medication such as: hydrocodone, oxycodone, codeine, oxycontin, etc.
- This list includes but is not limited to tranquilizers such as: alprazalam, xanax, valium, diazepam, etc.
- This list includes but is not limited to stimulants such as: Adderall, Ritalin, Concerta, etc.

If you require these on an ongoing basis, please inform the receptionist before completing this form. Some exceptions are made by submitting medical records from previous physicians and asking for review before appointment. A physician will then review your record and we will notify you if we are able to manage your medical care on a long term basis.

## Statement of Financial Responsibility

**AS A SELF-PAY PATIENT:**
I attest that I have not presented any evidence of insurance coverage, or, I have ARkids 1st or Medicaid, but Dr. Wade Fox is not my Primary Care Physician. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered, and I possess the means to tender payment today.

I understand that I will be asked a for $100 deposit prior to being seen at each visit. Any additional amounts due must be paid at the end of each visit. Any overpayment will be credited back at the end of each visit.

If I have concerns about the amount of my charges incurred, I will ask a member of the medical staff before charges are incurred.

**WellQuest Medical & Wellness reserves the right to withdraw further care if patient does not fulfill the obligation made under the above financial arrangements.**

**AS AN INSURED PATIENT:**
I understand that WellQuest Medical & Wellness will assist me in submitting my medical claim to my insurance carrier. I hereby authorize payment directly to WellQuest Medical & Wellness and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services.

In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. I understand that statement balances are due at time of receipt.

**WellQuest Medical & Wellness reserves the right to withdraw further care if the patient does not fulfill the obligation made under the above financial arrangements.**

## Communication

In the event that WellQuest Medical & Wellness needs to contact you regarding lab results, testing, or x-rays, a reliable form of communication will be needed. Please select the following methods of preferred communication:

☐ A detailed message may be left at my: ☐ Home ☐ Work ☐ Both
☐ A message with a call back number only may be left at my: ☐ Home ☐ Work ☐ Both
☐ It is okay to fax information to me at the following number: _____
☐ I only allow _____ (Name) to receive the following information:
☐ Appointment Information ☐ Billing Information ☐ Lab Tests or Reports ☐ Prescription or Medication information

## Acknowledgement

☐ I have read and accept the above responsibilities.

Client / Guardian Name: _____ Relationship: _____
(Please Print)

Client / Guardian Signature: _____ Date: _____



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## Patient Notice of Our Privacy Practices

**Please review the following notice that describes how medical information about you may be used and disclosed and how you may get access to this information.**

This is NWA Primary Care Physicians ("Clinic's") notice to you of how certain health information regarding you may be used or disclosed by this Clinic. We are required by law to provide you with a description of our privacy practices. Should you have any questions concerning this Notice, contact the Privacy Officer named below:
• The effective date of this Notice is April, 2003. You will be provided, either by mail or in person with a copy of any amendments or changes to this Notice.
• This Notice should be delivered to you no later than the date of the first encounter with you as a patient or, in an emergency situation, as soon as possible after the emergency treatment situation.
• This Clinic is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to your protected health information.
• Should you believe that your privacy rights have been violated, you have the right to file a complaint with the privacy Officer or with the Secretary of Health and Human Services at the address set forth below. Complaints should be in writing with a description of the events under which you believe your privacy rights were violated. Please give us as much detail as possible in your complaint. This will help us investigate your complaint. It is our policy not to retaliate against any patient for filing a complaint involving a violation of their privacy rights.

**Privacy Practices**
Disclosure of Your Health Information by Us - We may use or disclose your protected health information for purposes of treatment, payment or healthcare operations without your consent or authorization. This information may be transmitted by electronic transmission, by fax transmittal or by e-mail.
Treatment - "Treatment" is defined by the Department of Health and Human Services in its Privacy Standards as "...provisions, coordination, or management of health care or related services by one or more health care providers..." This means that for our own purposes we may use or disclose protected health care information among our employees and other staff professionals of the Clinic for the purpose of treating your medical condition. Furthermore, we may disclose your protected health information to other health care providers if we make a referral or if we seek consultation or review by another health care provider. An example of treatment might include a situation where your treating physician orders blood work or other types of diagnostic tests. The results of these tests might be reviewed by different professionals or caregivers and their conclusions would be used to assist in determining the appropriate therapies or plan of care for your treatment.
Payment - "Payment" is a rather broad term. An example of a "disclosure or use of protected health care information" for payment purposes would be submitting a claim to your insurance carrier so as to be reimbursed for our services. Other examples include activities such as determining eligibility of coverage under your insurance plan or answering questions by your insurance company so as to determine whether there was a medical necessity for the procedure or diagnosis performed by us or at our direction.
Health Care Operational - The final category under which we may use or disclose your protected health information without your permission is for activities performed by us such as quality assessment, case management and care coordination, contacting other providers about care alternatives for you, conducting internal training programs for supervisory purposes, and activities associated with the licensing and issuance of credentials for our staff.

**Our Contacts with You**
Periodically, we will issue appointment reminders, provide follow-up information on treatment alternatives, and possibly offer other treatment-related services to you. Typically, we conduct these contacts by mail and telephone. If you do NOT wish us to leave messages on your telephone answering machine or to receive mail at your residence, contact us. You do have the right to ask us to contact you in a confidential manner and we will do our best to accommodate you.

**Disclosure to Others**
You will be asked to sign protected health information than payment, treatment or to disclose your something other always have the right to revoke an authorization at any time, except to the extent this Clinic or any other providers have already taken an action in reliance upon your authorization.

**Disclosures Without Your Consent or Authorization**
Under Arkansas law, there are specific conditions or events that must be disclosed to third or state agencies whether or not you authorize this use or disclosure. These categories include:
(a) Incidents of suspected child abuse;
(b) Sexual assaults;
(c) Knife or gunshot wounds;
(d Domestic violence; and
(e) Sudden death of child.
In addition, Clinic participates in clinical research studies, which may involve your treatment. From time to time, we review our patients' protected health information to determine if they are suitable candidates to participate in clinical research trials. Before we will enroll you in such a research program or disclose your protected health information to third parties conducting clinical research trials, we will obtain your express authorization.
Your authorization, will, among other things, contain:
(a) A description of the extent to which your protected health information will be used or disclosed to other persons; and
(b) A description of any protected health information that will not be used or disclosed for purposes of or use in the clinical research trial.
As with any other authorization, you may revoke this authorization at anytime and ask that your protected health information no longer be used as part of the clinical research trials.

**Patient Individual Rights**
You have the following rights which may be exercised by you at anytime:
(a) The right to request restrictions on certain use and disclosure of your protected health information. However, please note that we will not be required to agree to these restrictions, particularly if, in our opinion, they interfere with treatment, payment, or other health care operations. However, we are willing to work with you in good faith to implement any restrictions you request. Should we disagree with the restrictions you place upon us, we will notify you in writing and suggest alternatives including seeking another health care provider.
(b) You have the right to receive communications from us in a confidential manner as noted above.
(c) You have the right to inspect a copy of your health information in our file at anytime.
(d) You have the right to amend incorrect or incomplete information or to provide a statement as to the reasons you believe the amendment regarding incorrect or incomplete information should be included in your file. However, we are not able to amend or alter health information about you we receive from another health care provider.
(e) You have the right to receive an accounting from us of all your protected health information made to third parties treatment, payment, or health care operations purposes. However, this accounting will be subject to certain restrictions and limitations as set forth below.

**Restrictions with Regard to Accounting**
Your right to an accounting will riot include the matters set forth below. An accounting with regard to your personal health information will NOT include items:
• Internal use by us of your information for treatment, payment or health care operations purchases.
• Disclosures made to you by us or at your request (or the request of your personal representative) to third parties.
• Disclosures made by you to our answering service or directory service when you contacted us after hours.
• Disclosures made to family members or friends in the course of providing care to you.
• Disclosures to correctional institutions.
• Disclosures made by us for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure by us for a specified period of time.
• Disclosures made to the Department of Health and Human Services, if you have filed a complaint with that organization believing that your privacy rights have been violated.
• Your right to receive a paper copy of this Notice, even if you have previously agreed to receive this Notice electronically.

**Questions & Concerns**
For more information or to file an internal complaint, contact the Privacy Officer.

Privacy Officer
WellQuest Medical & Wellness
3400 SE Macy, Suite 18
Bentonville, AR 72712
Phone: (479) 845-0880
Fax: (479) 845-0887

**The Privacy Officer listed above can provide you with the appropriate address for the United States Department of Health & Human Services.**