Primary Health & Wellness Centers

Patient Intake Form

Thank you for your interest in being a patient of Primary Health & Wellness Centers. This form is used to collect information about new patients and is used for internal purposes only. The information you supply is confidential and will be treated accordingly.

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: Home: _____ Mobile: _____

Ethnicity/Race: _____ Primary Language: _____

Marital Status: ☐ Single ☐ Married

☐ Divorced ☐ Separated

☐ Widowed

Emergency Contacts

Name (Primary Contact): _____

Relationship: _____ Primary Phone: _____

Name (Secondary Contact): _____

Relationship: _____ Primary Phone: _____

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers

Living Will Declaration

This declaration is solely for this practice and is not transferrable outside of this practice.

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending provider to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment (check only one box on each line):

I do	□	or do not	□	want cardiac resuscitation.
I do	□	or do not	□	want mechanical respiration.
I do	□	or do not	□	want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I do	□	or do not	□	blood or blood products.
I do	□	or do not	□	want any form of surgery or invasive diagnostic tests.
I do	□	or do not	□	want kidney dialysis.
I do	□	or do not	□	want antibiotics.
I do	□	or do not	□	want to make an anatomical gift of all or part of my body, subject to the following limitations, if any (list any excluded body parts):

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other instructions:

I do □ or do not □ want to designate another person as my surrogate to make medical treatment decisions for me, should I become incompetent, in a terminal condition, or in a state of permanent unconsciousness.

Name of surrogate (if applicable): _____

Declarant's signature: _____ **Date:** _____

By signing below, I am declaring my intention to **not** make any of the above living will declarations.

Declarant's signature: _____ **Date:** _____

Primary Health and Wellness Centers
HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information (PHI).

The notice contains a patient's rights section describing your rights under the law. By your signature, you certify that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to review any changes and update your consent.

The Health Insurance Portability and Accountability Act of 1996 allows for the use of your protected health information (PHI) for treatment, payment, or healthcare operations.

You have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor any restrictions.

By signing this form, you consent to Primary Health & Wellness Centers' disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, the practice may still use your information to complete any actions initiated prior to your revocation of consent.

By signing this form, I understand that:

- My PHI may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of my information, but the practice does not have to agree to restrictions.
- I have the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? □ Yes □ No

May we leave a message on your answering machine at home or on your cell phone? □ Yes □ No

May we discuss your medical condition with any member of your family? □ Yes □ No

If YES, you MUST list below the name(s) of those whom you allow to receive information from us about your personal health information, treatment, and care. We cannot discuss any of your details to those you do not list.

_____

_____

By my signature or that of my legal representative, I consent to the above:

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Agreement to Participate in Surescripts E-Prescribing Services

Surescripts is a national healthcare prescription database system authorized by insurance companies, health care organizations, and the Centers for Medicare and Medicaid Services (CMS) following the legal provisions set forth in the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003.*

Surescripts enables the electronic prescribing ("e-prescribing") of prescriptions and interchange of prescription information between pharmacies and health care organizations' Electronic Medical Record (EMR) systems.

"E-prescribing" is a more convenient and efficient manner of providing your pharmacy with the prescription medications authorized by your medical providers. In fact, for those who are prescribed controlled medications, the Drug Enforcement Agency (DEA) and the Pennsylvania Department of Health mandates e-prescribing of controlled medications.

Our practice's EMR utilizes the Surescripts system as a primary means of information interchange with your pharmacy, to both receive prescription information and requests from pharmacies, as well as to send your prescriptions electronically.

Therefore:

I, _____, agree to participate in the Surescripts electronic pharmacy services that provides and coordinates electronic prescription receipt and transmittal services between Primary Health and Wellness Centers and any pharmacy that I select.

I understand the purpose of this agreement is to allow my medical provider(s) to access information through the Surescripts service to be used in the coordination of my medical care and to allow the electronic transmission of prescriptions and medication information to be sent to the pharmacy and also be requested by my pharmacy.

By my signature below, I attest that I understand this agreement will remain in effect for as long as I seek medical care with this practice. I further understand that this agreement will terminate if I transfer my care elsewhere, request terminations of this agreement, or after a period of three (3) years of my inactivity or interaction with this practice.

Please note that this agreement MUST be signed in order to receive any prescriptions from any of the providers at Primary Health and Wellness Centers.

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Medication Agreement

Primary Health and Wellness Centers, as a primary care practice, does not routinely prescribe certain controlled medications, including (but not limited to) benzodiazepines, stimulants, anxiolytics, hypnotics, sedatives, barbiturates, opioids, or controlled hormonal treatments. If we determine and recommend that a controlled medication be prescribed for a specific condition, we reserve the right to either prescribe such medications, or to refer you to a specialist practice that is able to prescribe such medication(s).

The purpose of this form is to ensure your understanding of our medication policy by outlining your responsibilities as well as ours to provide for the safest and most effective use of any medication being prescribed to you by our practice. Our responsibilities include:

1. Prescribing of medications based on medical necessity.
2. Monitoring your medication use and adjusting treatment as may be needed.
3. Providing guidance on proper medication use and potential side effects.

By initialing each item and signing below, I acknowledge these patient responsibilities:

_____ I will take my medications only as prescribed.

_____ I will not increase or decrease a dose, or stop my medication, without the knowledge and approval of my provider(s).

_____ I will only use the specific retail and mail-order pharmacies designated on the Surescripts Agreement unless I change my pharmacy with advance notice to my prescriber.

_____ I will inform Primary Health and Wellness Centers of any medications or medication changes prescribed by any other healthcare provider(s).

_____ I agree to schedule and attend regular appointments at Primary Health and Wellness Centers in order to receive ongoing prescriptions from their provider(s). I understand that failure to attend regular appointments as determined by my provider may result in a reduction of prescription quantities or cancellation of prescriptions.

_____ If I am prescribed any medication classified as “controlled”, I agree that in order to receive ongoing controlled medication prescriptions, I must both schedule and attend face-to-face appointments, as mandated by Federal law.

_____ If I am prescribed any medication classified as “controlled”, I agree not to obtain the same controlled medications from any other source other than Primary Health and Wellness Centers; and I agree to not obtain any other controlled medications from any other source without the knowledge and consent of the Primary Health and Wellness Centers provider.

_____ I understand that “early” refills will not be provided unless specifically approved by the prescriber.

_____ I agree to not share, sell, or give away my medications.

_____ I agree not to use, share, or request illicit (illegal) drugs and substances.

_____ I agree to store my medications safely to prevent loss or theft, and to ensure that my medications are safely out of the reach of children.

_____ I understand that if my medication is lost or stolen, such medications will not be replaced “early.”

Primary Health and Wellness Centers
Medication Agreement

_____ I agree to submit to random drug testing or "pill counts" if required by my provider(s).

_____ I agree to be referred to a specialized practice for the prescribing of any medication that Primary Health and Wellness Centers does not, cannot, or will not prescribe in its role as a primary care practice.

_____ I give consent for Primary Health and Wellness Centers to communicate with any other medical providers, pharmacies, health care organizations, or insurance companies involved in my care, regarding the prescribing of any medication provided by any provider at Primary Health and Wellness Centers.

_____ (Females only) I agree to inform Primary Health and Wellness Centers should I become pregnant, and I agree to abide by any changes or discontinuation of any medication therapy deemed by the provider(s) to be a risk to the pregnancy.

Consequences of Non-Compliance

_____ I understand and agree that if I fail to adhere to the terms of this agreement, or if I fail to be compliant with the prescribing directions, Primary Health and Wellness Centers may, at its sole discretion, 1) discontinue any medication of which I am noncompliant; 2) refer me to an outside provider or treatment program; or 3) terminate my care with Primary Health and Wellness Centers.

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health & Wellness Centers
Personal Health & Medication History

Allergies

Please list your allergies and describe the reactions to your body:

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Medications

Please list the medications you are currently taking including the dosage:

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

Medication: _____ **Dosage:** _____

*If you are currently taking **more** than four medications, please present your medication list or prescription bottles to the nurse*

Family Health History

Please list any major conditions/illnesses that your immediate family members have had:

Relative	Condition	Living?	Age if deceased
Mother			
Father			
Sibling			
Other:			
Other:			

Surgical History

Please list any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description of Surgery	Surgeon	Location	Year

Social History

Do you currently consume alcohol? □ Yes □ No If Yes, how many drinks per week _____

Do you currently:

Use tobacco and/or nicotine? □ Yes □ No

□ Cigarettes: packs per day: _____ # of years: _____

□ Smokeless (snuff): # cans/pouches per day: _____ # of years: _____

□ Nicotine: □ patches □ gum □ lozenges □ vape # of years: _____

Use any non-prescription drugs? □ Yes □ No

□ Marijuana: how often/day: _____ # of years: _____

□ Other: _____ how often/day: _____ # of years: _____

Drink caffeine? □ Yes □ No #cups/drinks per day: _____

Are you currently sexually active? □ Yes □ No

How frequently do you exercise? □ Daily □ Weekly □ Occasionally □ Rarely □ Never

Medical History

Have you ever had/been diagnosed with any of the following?

Condition	Yes	No	Condition	Yes	No
ADHD			Hyperinsulinemia		
Alcohol abuse			Hyperlipidemia		
Anemia			Hypertension		
Anxiety			Hypogonadism (male)		
Artificial prosthesis (joint, valve, stent)			Infection Problems		
Asthma			Insomnia		
Bleeding/blood disorders			Irritable Bowel Syndrome		
Benign Prostatic Hyperplasia (BPH)			Kidney Problems		
Cancer (type(s)):			Menopause		
Cardiac Arrest			Migraine		
Celiac Disease			Neuropathy		
Chest Pain			Onychomycosis		
Congestive Heart Failure			Osteoarthritis		
Chronic Fatigue Syndrome			Osteoporosis / osteopenia		
Chronic pain			Pulmonary Embolism		
COPD			Rheumatoid Arthritis		
Depression			Seizure disorder		
Diabetes (type):			Seasonal allergies		
Drug abuse			Shortness of Breath		
DVT/peripheral blood clots			Sinus Conditions		
Erectile Dysfunction			Skin disorders (incl. psoriasis, eczema)		
Fibromyalgia			Sleep disorders (incl. apnea, narcolepsy)		
GERD / chronic heartburn			Stroke (CVA)		
Headaches (NON-migraine)			TIA		
Heart disease (CAD, MI, stents)			Thyroid disease		
Heart murmur			Tremor		

Please list any other medical problems that you have had:

_____

_____

_____

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient Consent

By signing below, I hereby acknowledge, agree, and authorize all of the following:

A. Accurate Information. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

B. Patient Rights and Responsibilities. I understand that Primary Health & Wellness Centers maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

C. Release of Medical Information. I authorize the release of my health information to Primary Health & Wellness Centers in accordance with Primary Health & Wellness Centers's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring provider, primary care provider, and any provider(s) I may be referred to. Primary Health & Wellness Centers shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

D. Consent to Communication. I consent to receiving communications from Primary Health & Wellness Centers regarding appointment reminders, test results, and other necessary healthcare-related information via phone, emails, or channels.

E. Acknowledgment. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize Primary Health & Wellness Centers to retrieve and review my medical history and authorize Primary Health & Wellness Centers to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Medical Services Agreement

Medical Consent:
I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include (but are not limited to) medications, injections, taking of medical photographs, laboratory procedures, and/or imaging examinations provided to me or ordered for me, under general and/or special instructions of the medical providers and staff of Primary Health and Wellness Centers in the course of my care.

Financial Agreement:
I understand that all charges are due at the time of service. I agree to pay Primary Health and Wellness Centers for all charges for any healthcare services provided to me by the medical providers and other medical professionals. Acceptable forms of payment include cash, check, Visa, Mastercard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Primary Health and Wellness Centers is a participating provider with my insurance company, I understand that my insurance policy is a contract between myself and my insurance company, Primary Health and Wellness Center is not involved. In order for Primary Health and Wellness Centers to file claims and accept payments from my insurance carrier, I understand that I must provide and maintain current insurance information to the practice at the time of service. I understand that I may be entitled to refund of any monies paid at time of service if my insurance company pays in full for any services rendered. I also understand that I am completely financially responsible for any services rendered that are not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release:
I request the payment of authorized benefits, including Medicare, any other government sponsored program, private insurance, and any other health plans to be made to Primary Health and Wellness Centers for any services furnished by the practice. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Primary Health and Wellness Centers to disclose portions of or all of my records, including my medical records, to any person or corporation which is or may be liable for all or any portion of charges billed by Primary Health and Wellness Centers, including but not limited to insurance companies, healthcare service plans, governmental agencies, or worker's compensation or other insurance carriers. I authorize Primary Health and Wellness Centers to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Primary Health and Wellness Centers any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information:
I hereby authorize Primary Health and Wellness Centers to release any information in my chart to any medical provider, hospital, or medical institution to which I may be referred to assist in my care.

Release of Information and Assignment of Benefits:
1. I authorize the release of any medical information necessary to process any claims.
2. I hereby authorize Primary Health & Wellness Centers to apply benefits on my behalf for covered services rendered by the practice. I request the payment from my insurance company be made directly to Primary Health & Wellness Centers (or to the party who accepts assignments). I understand that I am ultimately responsible for payment of services rendered.
3. I certify that the information I have reported regarding my insurance coverage is correct.
4. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or myself at any time by submitting to the practice such revocation in writing.
5. I attest to update you to any changes to my insurance/health coverage.

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Patient Portal Access Authorization

Primary Health and Wellness Centers has implemented the use of a **Patient Portal** through our EMR system.

Our Patient Portal allows you to request appointments, request prescription refills, and send messages to staff and providers.

At this time, our patient portal is unable to provide access to test results ordered by our providers.

Please note that in order to have electronic access to any test results, including labs, imaging, or other tests performed by any third-party entity such as UPMC, AHN, Independence (Excela) Health, Quest, LabCorp, or others, we recommend that you **also** establish a patient portal account with such entities.

Our Patient Portal is accessed by your e-mail address. To set up your Primary Health and Wellness Centers Patient Portal access, please provide us with a valid e-mail address that will become part of your electronic chart.

By providing an e-mail address and signing below, we will provide you with a temporary password to access the portal at:

https://www.irwinfamilycare.com

This temporary password is valid for 24 hours only, and will require you to enter a new password upon initial login. If you are unable to access your Patient Portal within that time, you may request a new password.

Patient Name: _____ **Date of Birth:** _____

By signing below, I authorize Primary Health and Wellness Centers to add the following e-mail address to my chart. By providing this information, I request access to the Primary Health and Wellness Centers Patient Portal.

E-Mail Address: _____

Your temporary password: _____

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Authorization for Release of Protected Health Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

I have been a patient at (Previous Medical Facility) _____

I understand that the facility name/provider whose name I have entered, has legally protected health information about me or the person I represent. I understand that my treatment at Primary Health and Wellness Centers will not be affected, whether or not I sign this form. I hereby authorize the facility/provider listed below to release information:

Name of facility, agency, or entity to **release** health information:

Facility Name: _____ Phone: _____

Address: _____ Fax: _____

Name of facility to **receive** health information: Primary Health and Wellness Centers
905 Spruce Street
Irwin, PA 15642
Ph: 724.864.9595 FAX: 724.864.9860

I affirm and authorize that the types of records checked below are permitted to be released (HIV, Behavioral Health and Drug and Alcohol Information contained in the parts of the record(s) indicated above will be released through this authorization unless otherwise indicated):

- □ Medical History and Physical Exam
- □ Laboratory Reports/Tests
- □ Medical Provider (physician, NP, PA) Orders
- □ Consult Records
- □ Operative Records
- □ Hospital Records / Discharge Summaries
- □ Other (Specify):
- □ Progress Notes
- □ Radiology / Imaging Records
- □ Medication / Prescription Records
- □ Psychiatric/Psychological Records
- □ Pathology Reports / Records
- □ Mammography Reports
- □ **ALL MEDICAL RECORDS for the last 2 years**

I do NOT authorize the release of the following records (check all that apply):

□ Behavioral Health (Psychiatric) □ Drug/Alcohol □ HIV

This authorization will expire in 90 days or (specify): _____

Primary Health and Wellness Centers
Authorization for Release of Protected Health Information

By my signature below, I affirm that I understand the following:

- My health records will not be released or obtained by Primary Health and Wellness Centers **unless** my written permission is provided for, as evidenced by my (or my legal representative's) name and signature on this Authorization for Release of Protected Health Information.
- The release of my health records by the facility/person named above may be re-disclosed by the facility/person that receives the records and therefore (1) its providers and staff have no responsibility or liability as a result of such re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- This authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented. However, no time frame shall go beyond one (1) year from the date of signature.
- I have the right to revoke this authorization form at any time by sending a written request to the entity where the authorization was provided.
- Any decision on my part to revoke this authorization does not apply to any release of my health records that have been received **prior** to the date of my request to revoke this authorization.
- I am entitled to a copy of this authorization form.

General Authorization

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____

Primary Health and Wellness Centers
Authorization for Release of Protected Health Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

I have been a patient at (Previous Medical Facility) _____

I understand that the facility name/provider whose name I have entered, has legally protected health information about me or the person I represent. I understand that my treatment at Primary Health and Wellness Centers will not be affected, whether or not I sign this form. I hereby authorize the facility/provider listed below to release information:

Name of facility, agency, or entity to **release** health information:

Facility Name: _____ Phone: _____

Address: _____ Fax: _____

Name of facility to **receive** health information: Primary Health and Wellness Centers
905 Spruce Street
Irwin, PA 15642
Ph: 724.864.9595 FAX: 724.864.9860

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- □ Laboratory Reports/Tests
- □ Medical Provider (physician, NP, PA) Orders
- □ Consult Records
- □ Operative Records
- □ Hospital Records / Discharge Summaries
- □ Other (Specify):
- □ Progress Notes
- □ Radiology / Imaging Records
- □ Medication / Prescription Records
- □ Psychiatric/Psychological Records
- □ Pathology Reports / Records
- □ Mammography Reports
- □ **ALL MEDICAL RECORDS for the last 2 years**

I do NOT authorize the release of the following records (check all that apply):

□ Behavioral Health (Psychiatric) □ Drug/Alcohol □ HIV

This authorization will expire in 90 days or (specify): _____

Primary Health and Wellness Centers
Authorization for Release of Protected Health Information

By my signature below, I affirm that I understand the following:

- My health records will not be released or obtained by Primary Health and Wellness Centers **unless** my written permission is provided for, as evidenced by my (or my legal representative's) name and signature on this Authorization for Release of Protected Health Information.
- The release of my health records by the facility/person named above may be re-disclosed by the facility/person that receives the records and therefore (1) its providers and staff have no responsibility or liability as a result of such re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- This authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented. However, no time frame shall go beyond one (1) year from the date of signature.
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- Any decision on my part to revoke this authorization does not apply to any release of my health records that have been received **prior** to the date of my request to revoke this authorization.
- I am entitled to a copy of this authorization form.

General Authorization

Patient/Legal Representative Name (print): _____

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Date:** _____