Frank Institute for Health & Wellness
1630 MILITARY CUTOFF ROAD, SUITE 104
WILMINGTON, NC 28403
910.679.8534 (TEL)
910.679.8535 (FAX)

PATIENT INFORMATION

Last:	First:	MI:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:		State:	Zip:	
Home Phone (Do not leave messages ❑)	Work Phone (Do not leave messages ❑)		Cell Phone (Do not leave messages ❑)		
Social Security Number: - -	Email Address:				
Marital Status: ❑ S ❑ M ❑ W ❑ D	Do you drive? ❑ Y ❑ N	Preferred Contact Method: ❑ Phone ❑ Email ❑ Letter			
Race (check one): ❑ White ❑ African American ❑ Asian ❑ Native American ❑ Other	Ethnicity (check one): ❑ Hispanic/Latino ❑ Non-Hispanic/Latino	Preferred Language (if not English): ❑ Spanish ❑ Other: _____			
Employer & Employer Address:	Occupation: _____ ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Student				
Name of Spouse (if applicable)	Phone Number:	Emergency Contact Name & Relationship:	Phone Number:		
Who referred you to this office?	Preferred Pharmacy, location, & phone number:				

INDIVIDUAL RESPONSIBLE FOR PAYMENT (check if same as patient ❑)

Last:	First:	MI:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:		State:	Zip:	
Home Phone (Do not leave messages ❑)	Work Phone (Do not leave messages ❑)		Cell Phone (Do not leave messages ❑)		
Social Security Number: - -	Email Address:				

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MEDICAL HISTORY
(Check all that apply to you and provide details below)

❑ ADD / ADHD	❑ End Stage Renal Disease (Kidney Disease)
❑ Allergies (seasonal)	❑ GERD
❑ Alcoholism	❑ Heart Disease
❑ Anemia	❑ Hepatitis (❑ A ❑ B or ❑ C)
❑ Anxiety	❑ Hypertension (High Blood Pressure)
❑ Arthritis	❑ HIV/AIDS
❑ Asthma	❑ Hypercholesterolemia (High Cholesterol)
❑ Atrial Fibrillation	❑ Thyroid Disease
❑ Benign prosthetic hypertrophy (BPH)	❑ Lymphoma
❑ Blood Clots	❑ Osteopenia / Osteoporosis
❑ Cancer, type(s):	❑ Seizures
❑ COPD	❑ STD (s)
❑ Coronary Artery Disease	❑ Stomach / Colon Disease
❑ Depression	❑ Stroke
❑ Diabetes (Type 1 or Type 2)	❑ Other:

Please describe any issues listed above:

SURGICAL HISTORY
(Check all that apply and provide details below)

❑	Appendix, Date:	❑	Ovaries, Date:
❑	Bladder, Date:	❑	Pancreas, Date:
❑	Breast, Date:	❑	Prostate, Date:
❑	Colon, Date:	❑	Rectum, Date:
❑	Gallbladder, Date:	❑	Skin, Date:
❑	Heart, Date:	❑	Spleen, Date:
❑	Joints, Date:	❑	Testicles, Date:
❑	Kidney, Date:	❑	Uterus, Date:
❑	Liver, Date:	❑	Others, Date:

Please describe any issues listed above:

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PLEASE LIST <u>ALL</u> MEDICATIONS YOU CURRENTLY TAKE

(prescribed or over the counter)

This is very important so that we do not prescribe to you any medications that will cause harmful reactions from the medications that other doctors have prescribed to you.

MEDICATIONS TAKEN	DOSAGE	HOW OFTEN

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PLEASE LIST ALL ALLERGIES AND/OR ALLERGIC REACTIONS YOU HAVE TO ANY MEDICATIONS

(INCLUDE ALLERGIES SUCH AS LATEX AND ADHESIVES)

MEDICATIONS AND/OR SUBSTANCE	REACTION

SOCIAL HISTORY

(Check all that apply, if selected expand on below)

Smoking: Do you smoke? ❑ Y ❑ N How many cigarettes/cigars per day? _____
# of years smoking _____ Do you chew tobacco? ❑ Y ❑ N
Have you thought about quitting? ❑ Y ❑ N Have you quit before? ❑ Y ❑ N
Alcohol: Do you drink alcohol? ❑ Y ❑ N What type of alcohol? _____
How many drinks per day? _____ How many drinks per week? _____
Drugs: Do you take recreational drugs? ❑ Y ❑ N
What types of drugs? _____
When do you use them? _____
Exercise: Do you exercise? ❑ Y ❑ N
What activities do you partake in? _____
How many times per week? _____
Sexual Activity: Are you sexually active? ❑ Y ❑ N How frequent? _____
Diet: Are you currently on a diet? ❑ Y ❑ N What type? _____
Caffeine: Do you drink caffeinated beverages? ❑ Y ❑ N How many do you consume per day? _____ What types? _____
Depression: Have you recently noticed an increase in sadness? ❑ Y ❑ N Have you lost interest in enjoyable activities? ❑ Y ❑ N
Children: Do you have children? ❑ Y ❑ N
How many children do you have? _____
What are their sexes and ages? _____

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FAMILY HISTORY

	(Mother, Father, Brother, Sister, Grandparent,)
Cancer, type(s):	
CVA/Stroke	
Depression / Anxiety	
Diabetes	
Heart Disease	
High Cholesterol	
Hypertension (High Blood Pressure)	
Kidney Disease	
Thyroid Disease	

Please describe any issues listed above: (if applicable, list additional history if pertinent to your appt.)

_____

Please check and fill in the blank if applicable:

Father: ❑ Living ❑ Deceased (__ /__ /__) Cause: _____
Mother: ❑ Living ❑ Deceased (__ /__ /__) Cause: _____
Sibling 1: ❑ Living ❑ Deceased (__ /__ /__) Cause: _____
Sibling 2: ❑ Living ❑ Deceased (__ /__ /__) Cause: _____
Sibling 3: ❑ Living ❑ Deceased (__ /__ /__) Cause: _____

PRIMARY CARE HISTORY

Name of Primary Care Provider: _____
Name of Clinic Where They Practice: _____
Name of Referring Physician:_____
Date of Last Complete Physical Exam: _____
Date of Last Blood Work: _____
Date of Last Colonoscopy: _____
Date of Last Tetanus Shot: _____

FOR FEMALES:
Date of Last Menstrual Period: _____
Date of Last Pap Smear: _____
History of Abnormal Pap? Y ❑ N ❑ Date: _____
Date of Last Mammogram: _____

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WE TAKE THE PRIVACY OF YOUR MEDICAL AND PERSONAL INFORMATION VERY SERIOUSLY. PLEASE HELP US PROTECT YOUR PRIVACY BY COMPLETING ALL SECTIONS OF THIS FORM IN ITS ENTIRETY. THANK YOU.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE

_____
(Initial)

I acknowledge my rights and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Frank Institute for Health & Wellness may refuse to accommodate my request if it is not reasonable.

Please indicate the ***telephone number*** you would like our office to use for appointment reminders or other office communications (including but not limited to billing matters and test results): **(_____)_____-_____**

Please indicate the ***mailing address*** that you would like our office to use for appointment reminders or other office communications (including but not limited to billing matters and test results):

Street Address: _____

City: _____ State: _____ Zip: _____

Is there a family member or friend that you would allow us to leave messages with or release billing or medical information to?

Name / Relationship: _____ Phone #: **(_____)_____-_____**

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Consent for Purposes of Treatment, Payment and Healthcare

CONSENT FOR TREATMENT:

I do hereby consent to and authorize the performance of all examinations, treatments, and medical services deemed advisable by the physicians and staff of the Frank Institute for Health & Wellness to me or to the minor of whom I am the parent or legal guardian. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I fully understand this agreement and consent will continue until cancelled by me in writing.

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Frank Institute for Health & Wellness for charges for medically necessary services or services requested by or on behalf of the patient. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

_____ _____

Signature of Patient or Personal Representative ***Date***

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PAYMENT & CANCELLATION POLICY

Thank you for choosing Frank Institute for Health & Wellness as your provider. We are committed to providing you with quality care and service to all of our patients. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check and all major credit cards. * A returned check fee in the amount of $35 will be charged in the event of a bounced check (initial _____).

Insurance. We are out-of-network for most insurance plans, including Medicare. What this means is that we do not file insurance claims on your behalf, instead if you are insured by a plan and would like to file for reimbursement, we can provide you with the necessary procedure and diagnosis codes for potential reimbursement. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for our patients. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented this policy:

1. We request you give our office a 24-hour notice in the event you need to reschedule or cancel your appointment (or by 3pm on Friday for a Monday appointment).
2. If you miss your appointment and do not contact us with proper notice, we will consider this a missed appointment and a "no-show" fee for the amount of your appointment will be assessed to you. This applies to late cancellations and "no-shows."
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
4. Our office makes reminder calls for initial appointments. It is ultimately the patients responsibility to remember their schedule appointments.

Copies of Medical Records. Our office will gladly make copies of medical records for you. The fee for this service is based on the number of pages copied. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00, payable in advance.

We thank you for trusting the Frank Institute for Health & Wellness with your medical care.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

_____ _____

Signature of Patient or Personal Representative ***Date***