Premise Health™
Keep your edge.

Treatment and Medication History Consent and Patient Acknowledgment of the Notice of Privacy practices and Consent to Use and Disclose Health Information

I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered so that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

If required by law, I acknowledge that I was provided with an opportunity of a copy of the Premise Health Notice of Privacy Practices regarding uses and disclosures of information regarding me and my health ("Health Information"). I hereby consent to the use and disclosure of my health information, for the purposes and activities permitted under the federal privacy and state privacy laws, which are described in the Premise Health Notice of Privacy Practices.

I specifically authorize the release, to the fullest extent permitted by law, for treatment, payment or operations purposes as described in the Notice of Privacy Practices, of information regarding the results of any HIV/AIDS testing or treatment, mental health treatment and substance abuse treatment.

I authorize Premise Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records.

I authorize Premise Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I have read and do understand the above information.

_____ _____

Patient/Personal Representative Signature Date

_____ _____

Patient/Participant Name (please print) Date of Birth

Relationship of Personal Representative (parent/legal guardian): _____

FOR SITE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Patient did not sign or refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please describe: _____)

Premise Health

Patient Communication Preferences

Patient Name_____ Site Name_____

As defined in the Health Insurance Portability and Accountability Act (HIPAA), a patient may request that their Protected Health Information (PHI) such as appointment reminders, medical records, or laboratory results, be communicated by "alternative methods" of their choosing, if the facility can reasonably agree. Examples of "alternative communications" may include email, fax, work or cell number(s) and/or voicemail or answering machine. Premise Health will accommodate any reasonable request.

I request that Premise Health communicates with me only in the following way(s):

Home phone_____ Work phone_____ Cell Phone_____ voicemail permitted? Y N

Fax_____ US Mail address_____
By providing my fax or US Mail, I accept the risk that communications may be subject to exposure to / by other users of the fax machine or others at that mailing address.

Email address_____
By providing my email address I understand that Premise Health's email standard is to transmit patient-identifiable information in encrypted format as a best-practice security standard to protect patient information. (initial one):

____ I request to receive email in encrypted format

____ I do not want email

____ I request to receive email in unencrypted format
By choosing unencrypted format I accept any risk associated with personal email being seen by other parties.

DISCLOSURES TO FAMILY, FRIENDS AND OTHERS INVOLVED IN HEALTH CARE OR PAYMENT

Premise Health may share my medical information with the individuals listed below who are involved in my care or payment for my care. If no names are provided by me or my personal representative, or if an emergency presents or if I am incapacitated, I understand that the clinician's best judgment will determine if my medical information is to be shared, and with whom it is to be shared.

1. Spouse (name)_____

____ clinical details, test results, diagnosis, treatment planning, appointment reminders
____ billing, co-pay, balance due, insurance, payment-related concerns
____ no restrictions

2. Children/Family Members (names)_____

____ clinical details, test results, diagnosis, treatment planning, appointment reminders
____ billing, co-pay, balance due, insurance, payment-related concerns
____ no restrictions

3. Others (names)_____

____ clinical details, test results, diagnosis, treatment planning, appointment reminders
____ billing, co-pay, balance due, insurance, payment-related concerns
____ no restrictions

4. ☐ None

_____ _____
Signature of Patient, Parent or Authorized Representative Patient Date of Birth

_____ _____
Relationship to Patient Date

Premise Health

Patient Intake Questionnaire

General Patient Information

☐ Employee	☐ Spouse/Significant Other	☐ Dependent	☐ Contractor/Vendor

Employee ID #	For non-employees: last 4 of social security number _____

Legal Name					
Primary Phone #	( )	Other Phone #	( )		
Email Address					
Home Address					
City		State		Zip	
Date of Birth	/ /	Gender	☐ Female	☐ Male	

Primary Physician / Provider

Physician/Provider Name	☐ None
Physician/Provider Phone #	( )

Emergency Contact

Name		☐ None	
Phone #	( )	Relationship	

Preferred Pharmacy

Pharmacy Name		Phone #	

Preferred Method of Communication

What is your preferred method of communication?	☐ Phone	☐ Email	☐ Mail

Insurance

Payor (Aetna, Cigna, BCBS, etc.)		Insured ID	
Relationship to Insured	☐ Self	☐ *Spouse	☐ *Child ☐ *Other

*If relationship to insured is not Self, complete Insured information below:

Insured Name					
Insured Address					
City		State		Zip	
Date of Birth	/ /	Insured Gender	☐ Female	☐ Male	

Patient Signature

Signature		Today's Date	/ /

Patient Intake Questionnaire

Patient Name: _____

If you have any questions or need assistance completing this form, please inform one of the health center staff members.

Reason for Visit	

Allergies – Please include medications, environmental and food allergies

☐ No Known Medication Allergies ☐ No Known Environmental Allergies ☐ No Known Food Allergies

Allergy/Sensitivity	Reaction

Medications – Please include supplements, vitamins and over the counter medications

☐ I do not take medications.

Medication, Supplements, and/or Vitamins	Dosage / How Much	Frequency / When
Example: Vitamin D	*100 mg*	*Twice a day*

Medical History - Please check all that apply.

Patient Intake Questionnaire

Patient Name: _____

Premise Health

Have you had or do you currently have any of the following conditions?		
☐ I have no medical history		
☐ Attention-Deficit / Hyperactivity	☐ Eczema / Dry Skin	☐ Nerve / Muscle Disease
☐ Allergic Rhinitis	☐ Emphysema	☐ Obesity
☐ Allergies	☐ Acid Reflux	☐ Brittle Bones
☐ Anemia	☐ Glaucoma	☐ Pneumonia
☐ Anxiety	☐ Headache	☐ Back curvature
☐ Arthritis	☐ Hearing Loss	☐ Seizures
☐ Asthma	☐ Heart Murmur	☐ Sickle Cell Anemia
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ Cataracts	☐ HIV/AIDS	☐ Substance abuse
☐ Heart Failure	☐ High Blood Pressure	☐ Thyroid Disease
☐ Bleeding Problems	☐ Inflammatory Bowel Disease	☐ Tuberculosis
☐ Do you have COPD or chronic bronchitis?	☐ Jaundice	☐ Ulcers (GI)
☐ Depression	☐ Kidney Disease	☐ Bladder Infection / UTI
☐ Diabetes	☐ Brain / Spinal Cord Infection	☐ Chicken Pox
☐ Eating Disorder	☐ Heart Attack	☐ Vison Problems
☐ Others: (Please List)		

Surgical History - Please check all that apply. Please include year, if known.		
☐ I have no surgical history		
☐ Adenoidectomy _____	☐ Fracture Surgically Repaired _____	☐ Small Intestine Surgery _____
☐ Appendectomy _____	☐ G-tube _____	☐ Spine Surgery _____
☐ Brain Surgery _____	☐ Heart Surgery _____	☐ Umbilical hernia _____
☐ Heart Bypass _____	☐ Hernia Repair _____	☐ Heart Valve Replacement _____
☐ Gall Bladder Removed _____	☐ Inguinal Hernia _____	☐ Vasectomy _____
☐ Colon or Large Intestine Surgery _____	☐ Joint Replacement _____	☐ VP Shunt _____
☐ Cosmetic Surgery _____	☐ Lymph Node Biopsy _____	☐ Others: (Please List):
☐ Eye Surgery _____	☐ Prostate Surgery _____	

Health Maintenance

Patient Intake Questionnaire

Patient Name: _____

Date of last physical exam?	☐ unknown	Date of last tetanus shot?	☐ unknown
Date of last flu shot?	☐ unknown	Date of last pap smear?	☐ unknown
Date of last pneumonia shot?	☐ unknown		

Family History – Please check applicable family member & age of onset or death, if known.

☐ I was adopted ☐ Family history unknown ☐ Family history negative for all listed conditions

Illness / Medical Problem	Father	Mother	Brother	Sister	Other	Age
☐ Alcohol Abuse	☐	☐	☐	☐		
☐ Arthritis	☐	☐	☐	☐		
☐ Asthma	☐	☐	☐	☐		
☐ Birth Defects	☐	☐	☐	☐		
☐ Cancer Type _____	☐	☐	☐	☐		
☐ COPD / Chronic Bronchitis	☐	☐	☐	☐		
☐ Depression	☐	☐	☐	☐		
☐ Diabetes	☐	☐	☐	☐		
☐ Drug Abuse	☐	☐	☐	☐		
☐ Early Death	☐	☐	☐	☐		
☐ Hearing Loss	☐	☐	☐	☐		
☐ Heart Disease	☐	☐	☐	☐		
☐ Hyperlipidemia	☐	☐	☐	☐		
☐ High Blood Pressure	☐	☐	☐	☐		
☐ Kidney Disease	☐	☐	☐	☐		
☐ Learning Disabilities	☐	☐	☐	☐		
☐ Mental Illness	☐	☐	☐	☐		
☐ Mental Retardation	☐	☐	☐	☐		
☐ Miscarriages / Stillbirths	☐	☐	☐	☐		
☐ Strokes	☐	☐	☐	☐		
☐ Vision Loss	☐	☐	☐	☐		

Patient Intake Questionnaire

Patient Name: _____

Premise Health

Social History

Tobacco

Do you use tobacco?	☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Passive
	☐ Former Smoker	☐ Heavy Smoker	☐ Light Smoker
	☐ Never		
If *YES*, type(s) of tobacco used:	☐ Cigarettes	☐ Cigars	☐ Smokeless
	☐ Pipes	☐ E-cigarettes	
Packs/Day:	☐ 0	☐ 1	☐ 3
	☐ 0.25	☐ 1.5	☐ Other (Specify):
	☐ 0.5	☐ 2	
Years:	☐ 0	☐ 4	☐ Start Date:
	☐ 0.5	☐ 5	
	☐ 1	☐ 10	☐ Quit Date:
	☐ 2	☐ 15	
	☐ 3	☐ Other (Specify):	
Smokeless Tobacco Use:	☐ Current User	☐ Former User	☐ Never Used
Comment on your history with Tobacco:			

Alcohol

Do you drink alcohol?	☐ Yes	☐ No	☐ Formerly
If *YES:* Drinks/Week	_____Glasses of Wine	____ Cans of Beer	___ Shots of Liquor
	_____ Standard Drinks or equivalent		
	Comments:		

Drug Use

	☐ Yes / ☐ No	If *YES*: Use/Week: _____	
Types: *Select all that Apply*	☐ Amphetamines	☐ Heroin	☐ Methylphenidate
	☐ Amyl Nitrate	☐ Hydrocodone	☐ Morphine
	☐ Anabolic Steroids	☐ Hydromorphone	☐ Nitrous Oxide
	☐ Benzodiazepines	☐ Ketamine	☐ Opium
	☐ "Crack" Cocaine	☐ LSD	☐ Oxycodone
	☐ Cocaine	☐ Marijuana	☐ PCP
	☐ Fentanyl	☐ MDMA (ecstasy)	☐ Psilocybin
	☐ Fluitrazepam	☐ Mescaline	☐ Solvent Inhalants
	☐ GHB	☐ Methamphetamines	☐ Other:
	☐ Hashish	☐ Methaqualone	

Patient Intake Questionnaire

Patient Name: _____

Premise Health

Sexually Active			
☐ Yes		☐ No	
If *YES: Partners:*	☐ Female	☐ Male	
If *YES: Birth Control / Protection:*	☐ None	☐ Implant	☐ Post - Menopausal
	☐ Abstinence	☐ Injection	☐ Rhythm
	☐ Coitus Interruptus	☐ Inserts	☐ Spermicide
	☐ Condom Male	☐ IUD	☐ Sponge
	☐ Condom Female	☐ Birth Control Pills	☐ Male Sterilization
	☐ Diaphragm	☐ Patch	☐ Female Sterilization
	☐ Emergency Contraception		☐ Ring
	☐ Other (Please List):		
	☐ Comments:		