New Patient Intake Forms

Please bring all labs and medical test performed, with results, from the past year to your appointment.

Due to sensitivities, our office is fragrance free. We ask that you do not wear scented products to our office. Thank you.

Patient Demographics

Name: First____________________Middle__________Last____________________________

Date of Birth:_______________ AGE:________ Gender: Male ○ Female ○

Ethnicity: (Circle)

White African American Hispanic Indian/Asian

American Indian Other

Marital Status: Single Married Widowed Divorced

Where were you raised?:____

What type of work do you do?:____

Primary Address:

Street:____Apt #__________________________

City:__________________________ State:__________________ Zip:____________________

Mailing Address:

Street:____Apt #__________________________

City:__________________________ State:__________________ Zip:____________________

Contact Information:

Home phone:__________________________ Cell phone:___________________________

Cell Phone Provider (Required) ____

Work phone:______________________Email:_______________________________________

Emergency Contact:

Name:__________ Phone:__________

Relationship:__________ Street:__________

City:__________ State:__________ Zip:__________

Additional Information:

Primary Physicians Name: __________

Phone:__________ Fax:__________

How did you hear about us? __________

Primary Pharmacy Information:

Name:__________ Phone:__________

Street:__________ Fax (**Required**): __________

City:__________ State: __________ Zip:__________

Compounding Pharmacy Information:

Name:________________________ Phone:________________________

Street:________________________ Fax **(Required)** : ________________________

City:__________________ State: ________________ Zip:__________

Chief Complaint – Why are you coming in?

____
____
____
____
____

Medications and Supplements: Including any hormone replacement, IUD, or birth control pills

____
____
____
____
____
____
____
____
____
____

Surgeries – Please include year of surgeries (If hysterectomy please state if ovaries were removed or left intact)

Hospitalizations

Allergies

Meds/Other	Reaction

Family History-

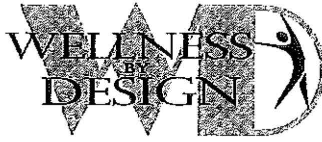
- **Cancer**-Family member/type?______________________________
- **Diabetes-**______________________________________
- **Depression-**____________________________________
- **Endometriosis-**_________________________________
- **Heart disease (heart attack, stroke)-**________________________
- **High blood pressure-**______________________________
- **Osteoporosis-**_________________________________
- **Autoimmune (be specific)** ____________________________
- **Other** ____

Dental History:

- ☐ Silver mercury fillings
- ☐ Tooth pain
- ☐ Implants
- ☐ Bleeding gums
- ☐ Gingivitis
- ☐ Problems with chewing
- ☐ Gold filling
- ☐ Root canals

Do you brush your teeth regularly? How many times a day?________________

Do you floss regularly?__________________________________



Current Symptoms

- ☐ **General** (fatigue, night sweats, unexplained weight change, brain fog)
- ☐ **Eyes** (visual trouble, trouble with eye pressure, eye redness/discharge)
- ☐ **Ears** (difficulty hearing, ringing in the ears)
- ☐ **Nose** (chronic discharge/drainage)
- ☐ **Throat** (sore throat)
- ☐ **Lungs** (wheezing, shortness of breath, snoring, asthma, wake gasping for breath)
- ☐ **Chest/Heart** (chest pain, palpitations, irregular heartbeat, Hx of rheumatic fever or heart attack)
- ☐ **Hematology** (easily bruised, trouble with blood clotting, nose bleeds, miscarriage)
- ☐ **Stomach/GI** (pain, nausea, heartburn)
- ☐ **Liver/Kidney/Bladder** (kidney stones, urinary frequency, blood in urine, prostate problems)
- ☐ **Bowel** (blood in stool, constipation, diarrhea, change in stool)
- ☐ **Circulation** (varicose veins, leg swelling/edema)
- ☐ **Musculoskeletal** (back pain, joint pains, leg pain)
- ☐ **Neurology** (headaches, dizziness, passing out migraine, stroke, seizures)
- ☐ **Allergy** (hives, itching, rashes)
- ☐ **Sleep** (trouble falling asleep, staying asleep, snoring, never feel rested)
- ☐ **Psychiatric** (depression, anxiety, bipolar, addictions)
- ☐ **Hormones** (menopause, low testosterone, thyroid issues)
- ☐ Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have the better we are able to assist you with your present symptoms.

Past Medical History

☐ Seizures	☐ Heart disease, arrhythmias, A-fib, heart attack, stroke	☐ Glaucoma
☐ Active GI bleed	☐ Drug or alcohol addiction	☐ Bulimia
☐ Breast Feeding	☐ Diabetes I or II	☐ Osteoporosis
☐ Auto Immune Disease	☐ Stent	☐ High Blood Pressure
☐ High Cholesterol	☐ Bladder Infections	☐ Stomach Problems
☐ Fibroids	☐ Lung Disease	☐ Cancer or Tumors
☐ Heart Murmur	☐ Diverticulitis	☐ Tuberculosis
☐ Abnormal Pap Smear	☐ Stress	☐ Endometriosis
☐ Lupus	☐ Arthritis	☐ Blood Transfusion

Men Only:

Do you have a history of prostate disease? Yes No

Have you ever had an elevated PSA? Yes No

Do you have a history of prostate enlargement? Yes No

**If yes and on medication please list* ______________________

Do you have a history of prostate cancer? Yes No

Do you have urinary frequency? Yes No

Women only:

First day of last menstrual cycle?______________________

Age first cycle started? ______________ How long do they last?______________

Do you miss your period or have more than one per month? Yes No

Are your periods regular? Yes No Any heavy bleeding? Yes No

Do you have a history of infertility? Yes No

Are you on birth control? Yes No If yes, please list name and method

____

Have you had a hysterectomy? Yes No If yes, were the ovaries removed or left intact?__________

Are you pregnant? Yes No

Number of children __________ Number of deliveries ______________

Number of miscarriages ______________ Age at onset of menopause ______________

Have you completed menopause? Yes No

If yes, what year?______________________

Female disorders/hormonal imbalances:

Fibrocystic breast Painful periods Heavy periods
PMS

HORMONE SYMPTOM QUESTIONNAIRE

Patient Name: ______________________________ Date of Birth: ____________

Please circle one of the following categories below to let us know how you are feeling at today's appointment:

Current Status – What are your CURRENT Symptoms?

0 means you have no symptoms of this type at all / 1 means you have very mild symptoms of this type, 5 would be moderate symptoms and 10 would mean you have severe symptoms of this type.

(P)	Low ----------			Moderate	--------------			Severe	-------			Comments, if any
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	______
Depression	0	1	2	3	4	5	6	7	8	9	10	______
Irritability	0	1	2	3	4	5	6	7	8	9	10	______
Anxiety	0	1	2	3	4	5	6	7	8	9	10	______
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	______
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	______
Palpitations	0	1	2	3	4	5	6	7	8	9	10	______
(E)												
Painful Intercourse (Women)	0	1	2	3	4	5	6	7	8	9	10	______
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	______
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	______
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	______
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	______
Hair Loss (Women)	0	1	2	3	4	5	6	7	8	9	10	______
(T)												
Fatigue	0	1	2	3	4	5	6	7	8	9	10	______
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	______
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	______
Body-Joint Pains	0	1	2	3	4	5	6	7	8	9	10	______
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	______
Low Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	______
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	______
Erectile Dysfunction (Men)	0	1	2	3	4	5	6	7	8	9	10	______

Patient Signature: ______________________________ Date: ______________________

****Current Height:________________ MUST FILL OUT****

****Current Weight:________________ MUST FILL OUT****

Health Habits

Do you exercise?

- ☐ Sedentary
- ☐ Lightly active (1-3 days a week)
- ☐ Moderately active (3-5 days a week)
- ☐ Very active (6-7 days per week)

Do you smoke cigarettes? Yes No

If yes, how many per day? ________________________ How many years?____________________

Do you consume alcohol? Yes No

If yes, how often and how much? ____

Do you drink caffeine? Yes No If yes, how many cups a day? ______________________

Do you use marijuana or any other illegal substances? Yes No

If yes, please list____

Have you had any injuries? (Back, head, neck, broken bones)

If yes, please list____

Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have the better we are able to assist you with your present symptoms.

____

____

____

____

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for **Wellness By Design** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Wellness By Design** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Wellness By Design reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Wellness By Design, Constance Carver.**

With this consent, **Wellness By Design** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Wellness By Design** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Wellness By Design** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wellness By Design restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Wellness By Design** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Wellness By Design** may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

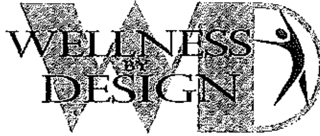
______________________________ ____________________

Print Patient's Name Date

____

Print Name of Patient or Legal Guardian, if applicable

Dr. Connie Casebolt and Wellness By Design
850 S. Pleasantburg Drive suite 103 Greenville, SC 29607



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. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to

the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa. All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer: Constance Carver at 850 S. Pleasantburg Drive Suite 103 Greenville, Sc 29607

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________ have received a copy of

(Name of Patient)

Dr. Connie Casebolt and Wellness By Design Notice of Privacy Practice

____

(Signature of Patient or Guardian)

____

Staff Will Fill Out Section if Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other: ______________________________

Medicare Opt-Out Private Contract

Medicare/Medicaid Disclaimer

Wellness By Design and its providers have opted out of Medicare and Medicaid. We do not accept Medicare nor Medicaid Insurance coverage. Wellness By Design will not bill Medicare and Medicaid for any medical services rendered to you. Also, wewill not provide you with insurance claim forms or any other information necessary to bill for your services directly by you to Medicare nor Medicaid.

By signing this contract, you as the Beneficiary are agreeing to the following:

- You will not submit a claim or request the provider to submit a claim, even if the services could be paid
- Acknowledge that Medigap or their supplement insurance plans may choose not to make payment to the provider under this contract
- Be responsible for payment of services when rendered
- Acknowledge that Medicare and/or Medicaid will not pay for these services
- Understand that the provider can charge any amount he/she sees fit
- Acknowledge that the Beneficiary has the right to go to another provider who has not "opted out"

By signing below, you acknowledge that you have read this document and agree to abide by our office policies and Medicare/Medicaid disclaimer.

______________________________	______________________________
Print Name (Beneficiary)	Witnessed By
______________________________	______________________________
Signature (Beneficiary)	Witness Signature
______________________________	______________________________
Print Name (Beneficiary's Legal Representative)	Date
______________________________	______________________________
Signature (Beneficiary's Legal Representative)	Date

HIPAA COMPLIANCE PATIENT CONSENT FORM

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

The notice contains a patient's rights sections describing your rights under the law. You ascertain that by your signature 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 update your signature/date.

You have the right to restrict how your protected health information 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 this agreement. The HIPAA (Health Insurance Portability And Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and 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, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information 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 the information, but the practice does not have to agree to those restrictions.
- The patient has 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? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by:______________________________(PRINT NAME PLEASE)

Signature: ______________________________ Date:______________________

Witness:______________________________ Date:______________________

Refund Policy

At Wellness By design we strive to provide the highest level of care and quality services. We understand that **YOU** are our greatest asset. We thank you in advance for understanding the necessity of our refund policy.

1. Refunds on supplements are not possible. All sales are final
2. There are no refunds on any service(s) paid for in advance. Individuals have the choice of allocating any unused credit(s) towards medical or aesthetic care for first degree family members OR substitute another service/product of the same value.
3. Exceptions will be made for pro-rated refunds in the case of death or ment or physical incapacitation of the patient
4. Credit card revocations are not accepted

Name Printed____

Signature____ Date_____________________