HOSKINSON
HEALTH & WELLNESS CLINIC

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	NAME CALLED	MARITAL STATUS
STREET ADDRESS	APT#	CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	SSN	SEX	DATE OF BIRTH
RACE	ETHNICITY		LANGUAGE	
EMPLOYER		SPOUSE'S NAME	EMPLOYER	
EMAIL		EMAIL		
OCCUPATION	BUSINESS PHONE	OCCUPATION	BUSINESS PHONE	
EMERGENCY CONTACT	PHONE	RELATIONSHIP TO THE PATIENT		
PRIMARY CARE PHYSICIAN PRACTICE PHONE #		REFERRING PHYSICIAN PRACTICE PHONE #		
HOW DID YOU HEAR ABOUT US?	o Flyer o Radio	o Social Media	o Newspaper	o Other_____

PRIMARY INSURANCE INFORMATION

POLICY HOLDER LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO PATIENT	
STREET ADDRESS	APT#	CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	SSN	SEX	DATE OF BIRTH
EMPLOYER		INSURANCE CO		POLICY #
EMAIL		MAILING ADDRESS		GROUP #
OCCUPATION	BUSINESS PHONE	PROVIDER CONTACT #		

SECONDARY INSURANCE INFORMATION

POLICY HOLDER LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO PATIENT	
STREET ADDRESS	APT#	CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	SSN	SEX	DATE OF BIRTH
EMPLOYER		INSURANCE CO		POLICY #
EMAIL		MAILING ADDRESS		GROUP #
OCCUPATION	BUSINESS PHONE	PROVIDER CONTACT #		

Best Form of Contact?
_____ PHONE _____TEXT

Do You Give Permission to Call or Text?
____ YES _____TEXT

What level of detail would you like in a voicemail reminder?
_____ _____NONE
_____ Brief Appointment Reminder
_____ Detailed Message

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Patient Name: _____

Date of Birth: _____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

This consent form authorizes Hoskinson Health & Wellness Clinic to obtain and review my prescriptions history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Hoskinson Health & Wellness Clinic can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Hoskinson Health & Wellness Clinic to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT NAME (Printed): _____

PATIENT DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

DATE OF SIGNING CONSENT FORM:
_____

Hoskinson Health & Wellness Clinic
201 West Lakeway, Ste 700
Gillette, WY 82718
Phone: 307-387-9850
Fax: 307-387-9890
www.hoskinsonhealth.com

HOSKINSON
HEALTH & WELLNESS CLINIC

Patient Name: _____

Date of Birth: _____

PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Privacy Practices is posted in our main lobby. The complete Notice of Privacy Practices in also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

We have found that the easiest way to identify persons who are inquiring about your information is for you to assign a security password to your account. Persons who call will be asked this password instead of your social security information. Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Hoskinson Health & Wellness Clinic has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy

Signature: _____

This acknowledgement was signed by: _____

Printed Name – Patient or Representative: _____

Relationship to Patient (if other than patient): _____

Date: _____

In front of: _____
(Practice representative)

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Patient Name: _____
Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If you are 18 years of age or older; we must have your permission to discuss your treatment, medical, or financial information, etc. with anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.

<u>*PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW***</u>**

I hereby give my consent for Hoskinson Health & Wellness Clinic and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following person(s), <u>other than myself</u>. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

2. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

3. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

Signature: _____ Date:_____

OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date:_____

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