***Please print**

Today's date: _____ Primary Care Physician: _____

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Birth date _____ Age _____ SSN _____ Sex _____

Street Address _____

City _____ State _____ Zip Code_____

Email Address _____

Phone number (home) _____ (cell)_____ (work)_____

Is it okay to leave a message for the above number? Y or N If Yes, which one? _____

If patient is a *minor* Parent Name: _____ Phone Number: _____

*You chose our clinic or you were referred to our clinic by (please circle one and specify)

Dr._____ Insurance Plan _____ Hospital _____

Other _____ Do you have other family members being treated here? Y or N

If Yes, who? _____

Insurance Information (*Please give your insurance card to the receptionist*)

Insurance company: _____ ID # _____ Group #_____

(Subscriber is the person responsible for the insurance. i.e., your parent/husband/wife is the one who has the insurance through their work and they are the subscriber)

Subscriber Name _____ DOB _____ SSN_____

*****RELATIONSHIP TO SUBSCRIBER:*** _____******

I authorize payments of insurance benefits to The Well Clinic for services rendered. _____ (*please initial*)

Consent (Assent to Treatment)

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I acknowledge that I have received, have read (or have had read to me), and understand the information about the treatment I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the clinician named below. I understand that developing a treatment plan with this clinician and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician. I am aware that I may stop my treatment with this clinician at any time. The only thing for which I will still be responsible is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I know that I must call to cancel an appointment at least 24 hours (one day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment in full. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the clinician may stop my treatment. My signature below shows that I understand and agree with all these statements.

_____ _____

Signature of Client Date

_____

Printed Name

_____ _____

Signature of Parent or Guardian (if client is a minor) Date

_____

Printed Name of Parent or Guardian

If divorced or separated, please indicate custody status _____

Late Cancellation and No-Show Policy

Please read and sign to acknowledge your consent.

You are responsible for keeping your appointments made with The Well Clinic. If you are going to miss your appointment, we require a notification via phone no later than 24 business hours before your scheduled appointment. Monday appointments should be cancelled no later than Thursday. Emails are not considered a form of cancellation. You must call the office at 225-692-4113.

Business Hours: Monday-Thursday 8:00 am-4:00 pm

Friday 8:00 am-12:00 noon

Please note: We adhere strictly to this policy for a few reasons.

1. Taking responsibility for appointments is a key aspect of any form of treatment or coaching. Calling to remind you of your appointment is a courtesy provided by The Well Clinic. You are ultimately responsible for keeping appointments whether that reminder occurs or not.
2. We have a waiting list. When you cancel appropriately, you are helping others to receive the help they need when they need it.

The fees for late cancellations and not showing up for appointments can be up to **$150** for **ALL** services at The Well Clinic.

If you accrue a late cancellation or no-show fee, you *will not* be able to make another appointment until the fee has been paid.

By signing below, you are acknowledging that you have read, understand, and consent to this policy.

_____ _____

Full Name [Printed] Date

_____ _____

Full Name [Signature] The Well Clinic Representative Signature

Consent to Use and Disclose Your Health Information ("PHI")

This form is an agreement between you and me/us. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

_____. When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.mywellclinic.com, or by calling us at 225-692-4113 or from our privacy officer. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority (if applicable)

_____

Signature of authorized representative of The Well Clinic

Date of NPP: _____ ☐ Copy given to the client/parent/personal representative

Credit Card Authorization Form

We have implemented a policy which enables you to maintain your credit card information securely on file with The Well Clinic. In providing us with your credit card information, you are giving The Well Clinic permission to automatically charge your credit card on file for your [or any other patient(s) you have listed on this form] co-pays/co-insurance, outstanding balances, and/or services.

Co-Pays/Co-Insurances: Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by check, cash, or a card different from the credit card on file.

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Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and then is still an outstanding balanced owed, The Well Clinic will notify you via phone and/or mail. If the balance is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Services and Products: Self Pay services and other fees are due at the time of the office visit. This card will only be authorized for the use of the credit card holder, or any person(s) listed below by the credit card holder. This agreement will expire upon termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.

Credit Card Information	
Card Type: MasterCard VISA Discover AMEX Other	
Cardholder Name (as shown on card):	
Credit Card #	
Expiration Date (mm/yy): _____/_____	CVV# (on back of card): _____
Cardholder ZIP Code (from credit card billing address):	
Please fill out the information below for any other person(s) you authorize this credit card for. Patient Full Name: _____ DOB: _____ Patient Full Name: _____ DOB: _____ Patient Full Name: _____ DOB: _____	

I, _____, authorize The Well Clinic to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Credit Card Holder's Signature: _____ Date: _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members/Friend

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Many of our patients allow family members such as their spouse, significant other, parents or children to call and request any medical/financial information. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information discussed/ released to any family member or friend, you must sign this form.

Name(s):	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Name (PLEASE PRINT) **Date**

_____

Patient Signature

17505 Old Jefferson Hwy
Prairieville, LA 70769
225-692-4113
www.mywellclinic.com
info@mywellclinic.com

I, the clinician, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

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Signature of Clinician

Date

Top of Form

☐ Copy accepted by client

☐ Copy kept by clinician.

Bottom of Form

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.