Wellness Life Center

New Patient Information

Patient Name: _____

Patient Date of Birth: _____

SSN: _____

Today's Date: _____

Gender: _____ Marital Status: _____

Last Primary Care Physician: _____

Mailing Address: _____

_____

Cell Phone: _____ Work Phone: _____

Home Phone: _____

Insurance Provider: _____

- Policy Number: _____
- Group Number: _____

Secondary Insurance Provider: _____

- *Policy Number:* _____
- *Group Number:* _____

Emergency Contact: _____

- Telephone Number: _____
- Relation to Patient: _____

Pharmacy Name: _____

- Pharmacy Contact Number: _____
- Pharmacy Address: _____

Georgia Hammond

WELLNESS LIFE CENTER, LLC

◆1180 5th St. SE. Cairo, GA 39828

◆ Phone: 229-397-5433 ◆ Fax: 229-397-5433

Jonathan Lynch, MD ◆Kendra Lynch, MD◆ Wendy Pearce, DNP, FNP-C ◆Temesia Calloway, FNP-C

New Patient Health Questionnaire

Current Medication List

Name	Dosage	Frequency	Prescriber	Indication
Ex. Lisinopril	*5mg*	*Once a day*	*Dr. Jonathan Lynch*	*Hypertension*

1. **Patient Medical History (Circle the Following)**

Heart Disease	Anemia or other blood disease	Severe headaches	Neck Pain
High Blood Pressure	Thyroid Disease	Seizures	Back Pain
High Cholesterol	Digestive Disease	Stroke	Sleep Apnea
Lung Disease	Kidney, Bladder, or Prostate Disease	Blood Clots	**Other:**
Diabetes	Cancer (past or present)	Depression/Mental Illness	**Other:**

If history of Cancer. What kind: _____ Date of Diagnosis: _____Surgeries for Cancer: _____
Name of Physician/oncologist/surgeon: _____ Location of physician/oncologist/surgeon: _____
If Diabetic. Approximate Date of Diagnosis: _____ Last A1C value: _____Date of last A1C: _____
Physician who ordered A1C/location: _____
Date of last Diabetic eye exam: _____ Location of exam/name of physician: _____

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2. Allergies

Medication	**Severity (Mild, Moderate, Severe)**	**Reaction:**
Ex. Codeine	*Moderate*	*Itching/Rash*

3. Surgeries

Surgery: *Ex. Gallbladder Removal*	Year: Surgeon:	[redacted]	Surgery:	Year: Surgeon:
Surgery:	Year: Surgeon:		Surgery:	Year: Surgeon:
Surgery:	Year: Surgeon:		Surgery:	Year: Surgeon:

4. Overnight Hospital Admission

Admit reason:	Approximate Date:
Admit reason:	Approximate Date:
Admit reason:	Approximate Date:

5. Family History (circle or write in response)

Father: (living/deceased)	High Blood Pressure	Diabetes	Cancer	Other	Other
Mother: (living/deceased)	High Blood Pressure	Diabetes	Cancer	Other	Other
Sisters: #____	High Blood Pressure	Diabetes	Cancer	Other	Other
Brothers: #____	High Blood Pressure	Diabetes	Cancer	Other	Other
Daughters: #_____	High Blood Pressure	Diabetes	Cancer	Other	Other
Sons: #____	High Blood Pressure	Diabetes	Cancer	Other	Other
Grandparents:	High Blood Pressure	Diabetes	Cancer	Other	Other

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6. Social History

- Do you smoke cigarettes? __Yes __No…If yes, _____(amount) per day, _____(number) of years of use
- Do you use other forms of tobacco? __Yes __No… If yes, type of tobacco_____
- E-Cigarette/ Vape use? __Yes __No
- Do you have a history of past tobacco/cigarette use? ___Yes __NO. If yes, type of tobacco used _____. How long ago did you quit? _____ Comments: _____
- Do you drink alcohol? ___Yes ___No… If yes, Circle which one(s) **Beer Wine Liquor** If yes, how often? Daily___, Weekly___, Monthly___, Yearly____? Comments: _____
- Marijuana/recreational drug use? __Yes __No… If yes, type of drug_____, ____per day, _____(number) of years of use

Comments: _____

How many children do you have? _____sons _____daughters.

Are you married? __Yes __No, Divorced? __Yes __No, Widowed? __Yes __No

Do you work? __Yes __No, If yes, where? _____ If no, are you disabled? __Yes __No

Religion? _____

7. Special Considerations

Are there any religious practices that would keep you from receiving certain medical care?

For example, blood transfusion. If yes, please explain: _____

8. Immunizations

Influenza (6months or older) Yes__ No__	Date received:
Pneumonia (65 years or older) Yes__ No__	Date received:
Tetanus Yes__ No__	Date received:
COVID-19 Yes__ No__	Date received:
Shingrix (Shingles vaccine) Yes__ No__	Date received:

Have you received any vaccines out of state? __Yes __No

If yes, what state: _____

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9. Falls

Have you had any falls in the last year? __Yes __No

If yes, did they result in an injury? __Yes __No… If yes, please explain _____

10. If you are a female over 40 where was your last mammogram preformed? _____
    - Date: _____ Ordering provider: _____
11. Over 50 years, last colonoscopy and/or Cologuard date: _____ Location: _____
    - Ordering Physician: _____

12. Past Medical Providers and Specialists

Provider/Specialty	**Name of Physician**	**Name of Practice**	**Location of Practice**
Example	*Dr. Lynch*	*Wellness Life Center*	*Cairo, GA*
Primary Care Physician			
Cardiologist			
Gastroenterologist			
Hematologist			
Nephrologist			
Neurologist			
Oncologist			
Ophthalmologist/Optometrist			
Orthopedic			
Pulmonologist			
Rheumatologist			
Surgeon			
Urologist			
Physical Therapist			
Endocrinologist			
Podiatrist			
Pain Management			
Gynecologist			
Psychologist/Psychiatrist			
ENT			
Weight Loss/Obesity Medicine			
VA Clinic			
Other:			
Other:			

13. If there is anything you need to share about your past medical history, please note below.

_____

_____

_____

_____

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PATIENT ACKNOWLEGEMENT FORM

Patient Acknowledgement of Understudying at Wellness Life Center, LLC Notice of Privacy Practices.

I understand that the patient's health information is private and confidential. I understand that Wellness Life Center, LLC worked very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Wellness Life Center, LLC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations.

Wellness Life Center, LLC had a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is available with the Front Office. I understand that I have the right to read the Notice of Privacy Practices before signing this acknowledgement.

Wellness Life Center, LLC may update this Acknowledgement and Notice of Privacy Practices. If I ask, Wellness Life Center, LLC, will provide me with the most current Notice of Privacy Practices.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving and accounting of disclosures as required by law; and requesting communication by specific methods of communications or alternative location.

Wellness Life Center, LLC has established procedures that help them meet their obligations to patients. These procedures may include other signature requirement, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Wellness Life Center, LLC by following these procedures if I choose to exercise any of my rights describes in the Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review a current copy of Wellness Life Center, LLC's Notice of Privacy Practices.

Name(s) of individuals (and phone numbers) we may release information to regarding your care:
Name(s): _____

- _____

Patient or legally authorized signature

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Welcome to Wellness Life Center, LLC and thank you for choosing us as your provider for primary medical care. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who will consistently strive to exceed your expectations to ensure that your experience with us is as comfortable and stress-free as possible.

As a patient centered wellness center, our approach is to provide our patients with comprehensive health care, which is focused on all aspects of your health and overall wellbeing, including emotional, family and social concerns. Along with your physician and other health care providers, you are the most important person in managing your health.

We Strive for Excellence

At Wellness Life Center we have set high expectations for our staff and leadership team. Our expectations are referred to as our 7 core values. These include; integrity, respect, dedication, servantship, kindness, patience, and excellence. We choose to operate with honesty and with a high moral conduct. We choose to be respectful to our colleagues and our patients. We choose to be dedicated to our work, each other, and our patients. We choose to serve one another including our patients and our community. We choose to operate with kindness towards others at all times. We choose to have patience in all circumstances and with all people. We choose to operate every aspect of our business with the highest quality.

How We Serve you

- We strive to maintain an ongoing relationship with you and your family to manage your healthcare needs.
- We have a strongly dedicated medical team that will assist you in coordinating care with other providers, specialists, and community resources if needed.
- Our team will have access to all of your health information through electronic records in order to effectively manage your care.
- We provide you with electronic access to your healthcare team and personal records through our Patient Portal and Healow App.

How You Can Help

- Talk with your primary care provider and team about any questions you have.
- Keep in touch with your team if further questions arise about your health.
- Take care of your health by following the plan recommended by your team.
- Schedule a complete physical exam at least once a year.
- Always let us know how we're doing and how we can improve.

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OFFICE HOURS

Our office is available Monday-Thursday 8:00am to 5:00pm and Friday 8:00am to 12:00 pm, and may be reached at 397-5433. Our Providers are available "after hours" 24 hours per day/365 days per year by calling Grady General Hospital at 229-377-1150 and asking to speak with the provider on call for Wellness Life Center. If you need an appointment, prescription refill or test results, please call during regular business hours.

APPOINTMENTS

Wellness Life Center is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, emergencies can and do occur. Our goal is to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

To ensure quality care, Wellness Life Center, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Wellness Life Center promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment, we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

NO SHOW POLICY

A "no show" is the term we use when a patient misses an appointment without cancelling it within one (1) business day in advance. Unfortunately, "No-Shows" inconvenience those patients who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of **$75.00** will be billed to your account. You will be sent a letter, along with the billed administrative fee, alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance

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along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within one (1) calendar year will result in a temporary suspension of services. In order to reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no show letter to evaluate your situation. In the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated

- Please Note No-Show charges are the patients responsibility and will not be billed to your insurance company.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

- If you are scheduled for an appointment, you will receive a message by telephone, email, or text message.
- Closings will be displayed on our website and on Facebook.

INSURANCE

Wellness Life Center accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at **397-5433.** It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage.

PAYMENTS

Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department. Wellness Life Center accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Wellness Life Center. It is the policy of Wellness Life Center to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

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PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Wellness Life Center of which Pharmacy you use and update us if this should change. Please allow up to three business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.

- **All medications must be brought to every appointment.**
- **Please note that we do not fill Narcotic Medications or order Antibiotics over the phone.**
- **Our Practice does not routinely order Narcotic Pain Medicine; therefore, you may be required to obtain these medications through a Pain Management specialist.**

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of **$20.00**. The law allows Medical Offices thirty (30) days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

COMPLETION OF FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Wellness Life Center will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow **7-14** days for completion of requested forms/letters.

The charges for completion of these forms is as follows.

If the form can be printed directly from the appointment summary checkout – no charge.

If forms must be completed outside of a scheduled office visit, we charge a flat fee of $10.00.

The payment is due at the time the forms are received / dropped off.

Please note that Wellness Life Center may require that patients schedule an office visit to complete certain paperwork. This will always be at the providers discretion.

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign

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up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

ADDITIONAL INFORMATION

If you have further questions or need additional information about our services, please feel free to call our office at 397-5433 and/or visit our website at www.wellneslifecenter.org.

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Wellness Life Center OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

_____

Printed Name

_____

Signature

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RX History Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving quality patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing the consent form you are agreeing that Wellness Life Center, LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Understanding all the above, I hereby provide informed consent to Wellness Life Center, LLC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient

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Dear patient,

At Wellness Life Center we work hard to provide top quality medical care. As we deliver these services to you, we also strive to maintain your patient privacy. We will never utilize your information in inappropriate ways. Likewise, we will not ask others outside of our office for your medical information without your permission. We may utilize your release of authorization form to obtain medical history, lab work, or images/x-rays as indicated to keep your preventive care measures up to date in your patient record here at Wellness Life Center. By signing the highlighted portions of the following release form, you are giving us permission to obtain medical information only as is appropriate to provide the highest quality medical care to you. We will place this form on file in your chart, which will allow us to work more quickly to obtain medical information essential to your medical care without having to interrupt your busy schedule. You only need to complete the highlighted portion on the following form. We will complete the rest for you as indicated, with your permission.

Should you choose to not place a signed copy on file, we can contact you to come by to sign an individual form each time it is needed. Again, we will never obtain medical information outside of what is necessary to provide appropriate care for you.

Sincerely,

Wellness Life Center Team

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Patient Name: _____**Date of Birth**_____

Address:_____

City/State/Zip:_____**Telephone**_____

I authorize the release of medical information as indicated below:

FROM:

Practice Name:_____

Address:_____

TO:

Name:_____

Address:_____

☐ I would like to pick up my records: please call me at _____ ☐ I would like to records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

☐ Outpatient notes
☐ X-Ray report(s)
☐ Pathology Report(s)
☐ Other Specify_____
☐ Laboratory reports
☐ X-ray Film(s)
☐ Immunization record
☐ All medical records

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests ☐ Yes ☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders ☐ Yes ☐ No/NA

Purpose of the release: Please indicate the reason for this release

☐ For another doctor
☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ To obtain disability
☐ Worker's care
☐ Armed forces requirement
☐ Other _____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according the [practice name's] privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by [Practice name] and may potentially be re-disclosed by the party who received these records. [Practice name], its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of the patient Date

_____ _____
Signature of legal representative and relationship to patient Date

_____ _____
Signature of witness Date

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PATIENT MENTAL HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name:_____ Today's Date:_____

Check box that applies to you best within the last two weeks

	Not at All (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could notice. Or the opposite of being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts you would be better off dead, or hurting yourself in some way				

Below to be completed by Medical Personnel:

Total Score_____

( ) Minimal 1-4

( ) Mild 5-9

( ) Moderate 10-14

( ) Moderately Severe 15-19

( ) Severe 20-27

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