New Beginnings Wellness Center & Spa
927 N. Trenton Street
Ruston, LA 71270
318.255.1155 PH
318.255.3181 FAX

New Patient CHILD

PATIENT INFORMATION

Last Name:	First Name:	MI: DOB:	Female Male
Home Address:	City:	State:	Zip:
Billing Address:	City:	State:	Zip:
Phone 1:( )	Home Work Cell		
Phone 2:( )	Home Work Cell		
Social Security Number:			
Emergency contact:	Phone: ( )	Relationship:	
Email Address:	Marital Status: Single Married Widow Divorced		

INSURANCE INFORMATION

Primary Insurance:		Policy Holder:	
DOB:	SS#:	Policy#:	Group#:
Secondary Insurance:		Policy Holder:	
DOB:	SS#:	Policy#:	Group#:
Name of Spouse or Parent (if a minor):			
Spouse's/Parent's Employer:		Telephone#:	

CREDIT CARD INFORMATION TO BE KEPT IN YOUR PRIVATE ELECTRONIC CHART

Name on Card:			
Card Type: VISA Mastercard	AMEXP	Discover	
Card Number:		Exp:	Security Code:
Billing Address:			

credit card information *IS REQUIRED* for our cancellation and no show policy.

POLICIES AND PROCEDURES (PLEASE read carefully and initial next to each line to indicate your full understanding)

Effective January 1, 2017

Due to an excessive number of last minute cancellations and no showing of appointments, we are updating our policy as follows:

____ New Beginnings Wellness Center & Spa operates on a **24 hour cancellation AND no show policy**. If you are unable to make your appointment, we ask that you please give us 24 hours notice. Consecutive last minute cancellations or no shows may result in refusal of future appointments or payment in full required prior to scheduling any future appointments. If you no show an appointment or give last minute notice, a fee of **$50** will be incurred.

____ New Beginnings Wellness Center & Spa does not offer refunds on test kits, supplements, or products. If an item does not agree with you, we will gladly exchange the item or give you store credit.

____ New Beginnings Wellness Center & Spa requires payment in full at the time all services are rendered. Unless prior arrangements are made, we do not have any form of payment plans available.

____ Spa parties and packages are available through the Office Manager. Spa parties will include an 18% gratuity added to your total.

____ Gift Certificates are not redeemable for cash, may not be returned, and expire six months from the purchase date.

By signing below, I agree to become a New Beginnings Wellness Center and Spa patient and I agree to the terms outlined in this patient agreement.

Patient Signature: ____ Date: ______________________________

Patient Name Printed: ____

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HEALTH ASSESSMENT		
Name:	DOB	
Mother's Name:	Father's Name:	
With whom does child live?		
What is most important to you about the medical care of your child?		
What specific concerns about your child would you like to address?		

MEDICATIONS & ALLERGIES					
Please list all your current medications and allergies (including vitamins and supplements)					
	Medication	Dose	Frequency	Taken for	Prescribed by
1.					
2.					
3.					
4.					
5.					
Allergies to medications and other items:					
1.				Reaction:	
2.				Reaction:	
Preferred Pharmacy:				Phone:	
Address:					

SOCIAL HISTORY & LIFESTYLE			
Daycare/Nanny:	School:		Grade:
List any problems at home/school/daycare (i.e. learning, behavior, etc).			
Who lives at home with your child?			
Are there any pets in the home?	Yes or No	If yes, what type?	
Diet (infants):	Breastfed	Formula	Solid Food
Diet (children or adolescents, please describe):			
Physical Activity			
Type:		# of days per week:	
Type:		# of days per week:	
Type:		# of days per week:	
Does anyone smoke in the home?	Yes or No		
If your child is less than 49", does he/she use a car seat (booster seat)?		Yes or No	
If your child is under age 13, does he/she ride in the backseat of the car?		Yes or No	
Do you feel safe in your neighborhood?	Yes or No		
Are there guns in your home?	Yes or No	If yes, are they unloaded and locked away?	Yes or No
Is there any history of abuse in your child's home or life (physical, sexual, emotional, neglect)?			Yes or No

FAMILY MEDICAL HISTORY		
Please list any family member whom may have or had the following:		
Alcohol Abuse:	Bleeding Disorders:	Deafness:
Arthritis:	Breast Cancer:	Dementia:
Bipolar Disorder:	Cystic Fibrosis:	Glaucoma:
Heart Attack:	Lymphoma/Leukemia:	Schizophrenia:
High Blood Pressure:	Osteoporosis:	Sickle Cell Anemia:
High Cholesterol:	Obesity:	Skin Cancer:
HIV:	Parkinson's Disease:	Stroke:
Inherited Anemias:	Prostate Cancer:	Substance Abuse:

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Asthma:	Cancer of Unknown Cause:	Thyroid Problems:
Autism:	Colon Cancer:	Depression:
Crohn's Disease	Diabetes:	Other Cancer:

PERSONAL MEDICAL HISTORY	
Pregnancy complications:	Delivery complications:
Delivery method: ___Vaginal ___C-Sect	Birth Weight
Multiple Births (twins, triplets) Yes or No	
Has your child ever had any problems with the following: If yes, please explain.	
___Alcohol or substance abuse	___Lungs
___Cancer	___Metabolism (diabetes, thyroid, etc)
___Blood	___Muscle, joint, bones
___Digestion	___Nerves and brain
___Ear, nose, throat, eyes	___Skin and hair
___ER Visits Type:	___Sleep
___Heart or Blood Vessels	___Social, mental or emotional health
___Hospitalizations Type:	___Surgeries Type:
___Infectious diseases	___Female health (menstrual problems, etc)
___Kidneys or bladder	___Male health (testicular lump/pain)
___Learning disabilities	___Other
Explain all YES answers:	

HEALTH MAINTENANCE & PREVENTION		
When was the last time your child:		
Visited the dentist:	Had a Wellness Exam:	
Female Health: Has your child started her period?	Yes or No	If so, at what age?
Has your child ever had a PAP smear?		
Are your child's immunizations current? Yes or No		

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize New Beginnings Wellness Center and Spa to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- The day-to-day healthcare operations of New Beginnings Wellness Center and Spa.

I have also been informed of, and given the right to review and secure a copy of the New Beginnings Wellness Center and Spa Privacy Policy, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. In understand that New Beginnings Wellness Center and Spa reserves the right to change the terms of this notice from time to time and that I may contact New Beginnings Wellness Center and Spa at anytime to obtain the current copy of this notice.

I understand d that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and healthcare operations, but that New Beginnings Wellness Center and Spa is not required to agree to these requested restriction. However, if New Beginnings Wellness Center and Spa does agree then New Beginnings Wellness Center and Spa is bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time; however, any use or disclosure that occurred prior to the date I revoke is not affected.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at New Beginnings Wellness Center and Spa.

Authorization to communicate Protected Health Information – Check all that apply:

New Beginnings Wellness Center and Spa may leave a detailed message on voicemail at my home #: (_____) ____________________
New Beginnings Wellness Center and Spa may leave a detailed message on voicemail on my cell #: (_____) ____________________
New Beginnings Wellness Center and Spa may speak with another person (spouse, family member) about my medical condition
___ **including** /___ **excluding** information related to mental health, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relation:____ Phone #: (____) _________________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify New Beginnings Wellness Center and Spa should I change one or more of the telephone numbers listed above.

______________________________	______________________________
Signature Date	Patient Name Date of Birth
______________________________	______________________________
Representative Name	Relationship to Patient

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FINANCIAL RESPONSIBILITY AGREEEMENT

Date: ______________________

Patient Name: ____

Insurance Carrier – Primary: ____

Insurance Carrier – Secondary: ____

New Beginnings Wellness Center & Spa, as a courtesy and as is customary for a physician office or clinic, will file a patient's medical claim to their insurance carrier with the intention of receiving payment.

It is the responsibility of the patient to verify their insurance information prior to their appointment. New Beginnings Wellness Center & Spa will also attempt to verify insurance; however, there are times when this information is not available at the time of service.

In the event services are rendered without insurance verification, the patient will assume all financial responsibility if any of the following is true:

1. It is deemed that your insurance policy was not effective or termed prior to the office visit.
2. It is deemed that you are not covered under the policy that you submitted.
3. The services and/or procedures rendered do not meet the terms of your policy. (ie: referrals, prior authorizations, etc.)

Any non-payment for services rendered at New Beginnings Wellness Center & Spa may result in termination of future services and/or procedures as well as outstanding balances being forwarded to a collection agency. Any expenses incurred through the use of a collection agency will also become the financial responsibility of the patient.

By signing below you demonstrate your understanding of the above stated policy.

____ ___________________________

Patient Signature Date

____

Patient Name (Printed)