



# HEALTHY HABITS WELLNESS CLINIC, INC.

"Your Health is Our Business"

www.HealthyHabitsWellness.net

14 S. Baltic Place  
Meridian, ID 83642  
Phone (208) 887-4872  
Fax (208) 887-6331

5216 E. Cleveland Blvd. Suite G  
Caldwell, ID 83607  
Phone (208) 454-8111  
Fax (208) 454-8877

## INFORMATION--APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Today's Date \_\_\_\_\_  
Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Your Social Security # \_\_\_\_\_

Your Driver's License # \_\_\_\_\_ Exp: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you have Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Spouse or Parent \_\_\_\_\_ Their Birth date \_\_\_\_\_

Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone # \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Spouse's Driver's License # \_\_\_\_\_ Exp: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Does your spouse have health insurance at work? Yes \_\_\_\_\_ No \_\_\_\_\_

How did you hear of Healthy Habits: \_\_\_\_\_

If referred by someone, who was it? (please name) \_\_\_\_\_

How payment will be made: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_

\_\_\_\_\_ Cash \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Health Insurance

\_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Automobile Insurance Policy

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

I hereby assign, transfer, and set over to **Healthy Habits Wellness Clinic** all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Initial Confidential Patient Case History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – OCCASIONAL**  
**F – FREQUENT**  
**C – CONSTANT**

**O F C**

### GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

### MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
  - Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

**O F C**

### GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

### EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

**O F C**

### CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

### RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

### SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

### GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

### FOR WOMEN ONLY

- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

### HABITS

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |                                     |   |   |   |
|---|-------------------------------------|---|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Chorea     | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria              | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Measles              | <input type="checkbox"/> Recreational Drugs |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Depression | <input type="checkbox"/> Goiter         | <input type="checkbox"/> Miscarriage          | <input type="checkbox"/> Scarlet fever      |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Gout           | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bulimia          | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Hypoglycemia   | <input type="checkbox"/> Pleurisy             | <input type="checkbox"/> Typhoid fever      |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Eczema     | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Candidacies      | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Lumbago        | <input type="checkbox"/> Polio                | <input type="checkbox"/> Venereal disease   |
|   |                                     |   | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Whooping cough     |

If you answered YES to any of the above conditions, please explain: \_\_\_\_\_

Have you ever been hospitalized or been under medical care for any operation/psychiatric care/alcohol or drug rehab?  Yes  No If yes, please explain: \_\_\_\_\_

**ALLERGIES/INTOLERANCES**

- None     X-Ray Dye     Sulfa     Pollen     Food     Soaps/Lotions     Environment     Adhesives
- Medication     Other: (List Substance and reaction) \_\_\_\_\_

What is your major complaint?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List surgical operation and years:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY: Please specify members of your family including extended family who have these illnesses.**

- CANCER: \_\_\_\_\_  
 HYPOTHYROIDISM: \_\_\_\_\_  
 HIGH BLOOD PRESSURE: \_\_\_\_\_  
 HYPOGLYCEMIA: \_\_\_\_\_  
 OBESITY: \_\_\_\_\_  
 HEART DISEASE: \_\_\_\_\_

**Current Medications: Prescriptions Only**

Medication/Dose/How often	Reason for Taking	Prescribing M.D.

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## HIPAA FORM

### Introduction

At Healthy Habits Wellness Clinic, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31st, 2003 and applies to all protected health information as defined by federal regulation.

### Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which HHWC is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures HHWC may contact patients with appointment reminders, requests for the patient to contact HHWC for appointments, notices and letters concerning medical findings. HHWC may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

### Individual Rights

Although your health record is the physical property of HHWC, the information belongs to you. You have the right to:

- 1 The right to request restrictions on certain uses and disclosures of your information;
- 2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- 3 The right to receive confidential communications;
- 4 The right to obtain a copy or inspect your health information;
- 5 The right to amend protected health information;
- 6 The right to receive an accounting of disclosures of protected health information.

### HHWC Center's Rights

1. HHWC has 30 days with which to comply with a patient's request to review or copy their health information. HHWC is allowed an additional 30 days if the record is off site. HHWC may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. HHWC will charge staff time for this service.

### HHWC Medical Center's Duties

1. HHWC is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. HHWC is required to abide by the terms of this Notice; and
3. HHWC reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

### Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W., Rm. 509F, HHH Building, Washington DC 20201.

Further Information-Please contact the SMC administrator at 747-5861 for further information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Signature (Check In) \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT'S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC**

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I without reservation waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

I understand that if I lose my medications, which are handed out on a bi-weekly or monthly basis, I will not be able to obtain a new supply until the following office visit whether it be bi-weekly or monthly. As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Printed name: \_\_\_\_\_

Office Staff representative \_\_\_\_\_

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### **Consent for Hormone Supplement Therapy**

I hereby request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the Nurse Practitioners of Healthy Habits Wellness Clinic. I acknowledge that there are no guarantees or assurances made to me with respect to the benefit of hormone supplementation therapy prescribed for me.

I understand that I will be in charge of the administering these hormones and supplements prescribed to me. I will strictly and consistently conform and comply with the recommended doses and methods of administration.

I understand that the initial blood test will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the clinic Nurse Practitioners any adverse reaction or problems that occur that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications, if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenations a purpose is an emerging medical and scientific therapeutic specialty and that there are not guarantees with respect to the treatment prescribed.

I understand that the role of the clinic Nurse Practitioners is limited to hormone replacement only. I agree that I am and will be under the care of my personal physician for all other medical conditions.

I have been informed about my insurance benefits. I understand that Medicare ***does not*** cover hormone supplementation therapy. I therefore agree to pay for all services, including laboratory and pharmacy charges that my insurance does not cover.

I have read and understand all the above and consent thereof, I have had other written information given to me explaining hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment from Healthy Habits Wellness Clinic and its Nurse Practitioners concerning hormone supplementation.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Pap/Pelvic Exam and Mammography Requirements**

This is to certify that I have read and understood the following information.

The American Cancer Society recommends that women over the age 40 or on hormone replacement therapy have annual pap smears and mammograms. If you have had a complete hysterectomy or hysterectomy with intact ovaries, it is recommended that you have a pap smear or pelvic exam every 2-5 years based on your personal medical history and your family history. The exact time frame can be decided by your health care provider. We require copies to be provided for your medical records.

If you are placed on bio identical hormone replacement therapy, it is imperative to follow these guidelines to protect your good health. You may discuss this with the nurse practitioner prior to signing if you have any questions.

I have read this requirement and agree to comply with it.

Patient Name: \_\_\_\_\_  
(Printed)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HEALTHY HABITS WELLNESS CLINIC

# Insurance Policy

1. The patient, parent or legal guardian (if patient is a minor) is responsible for any balance due, regardless of insurance coverage or anticipated insurance payment.
2. Healthy Habits Wellness Clinic will verify your insurance benefits. Please keep in mind that the verification is a description of your benefits as stated in your policy and IS NOT A GUARANTEE OF PAYMENT.
3. Your insurance payment should pay within 60 days. If your insurance has not paid within 60 days, an attempt to collect on the claim will be made. You will be asked to pay the balance due while we are attempting to collect from the insurance. If an overpayment exists, you may be eligible for a refund of what you have paid towards your balance. This excludes what the insurance has paid to us.
4. Co-payments and or estimated percentage of your responsibility and are due payable at time of service.
5. Our office will not enter into a dispute with your insurance company over your claim. We will do what we can to collect, however, should you disagree with a decision made by your insurance company, it will be your responsibility to pursue the dispute.
6. Should collection of your unpaid account be referred outside our office for collection, you are responsible for collections costs, including any reasonable attorney fees incurred in an arbitration, trial appearance, and or bankruptcy proceeding.

By my signature below I am verifying that I have read the above office policy and that I understand that I am fully responsible for my bill with Healthy Habits Wellness Clinic.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_