Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385, 860-572-7711, www.fwcct.com

Empowering LIFE

Date_____ Insurance_____

Patients First Name: _____ MI____ Last Name_____
Address: _____
City: _____ State_____ Zip_____
SS# _____ Gender_____ Age_____ Nickname_____
DOB ____/____/_____

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax_____
E-mail:_____
Spouse/Parent Name: _____ Marital Status: _____

Emergency Contact Information
Name_____
Phone_____ Relationship_____

Amount of physical activity performed at work_____
_____

Amount of physical activity a day_____

Reason for seeing the doctor_____

What are your goals for this visit? _____
_____

List Current Medications/Supplements/Treatment Protocols_____
_____
_____
_____

How did you hear about us? _____

How has this condition effected your LIFE? _____

Who can we thank for your referral? _____

How can we help Empower your LIFE?_____

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Social & Family History

Live with: ☐ Family ☐ Spouse ☐ Significant Other ☐ Friend ☐ Alone

Children: ☐ Yes ☐ No Ages: _____

Smoking History: ☐ Currently ☐ In the Past Years_____ Amount_____

Alcohol: ☐Yes ☐ No Amount_____ Substance Abuse: ☐ Yes ☐ No Type: _____

Education Level: ☐ Grade School ☐ High School ☐ College

Medical History

Yes	No	Do you have?	Yes	No	Do you have?
☐	☐	Allergies to any medications	☐	☐	Cardiac Pacemaker
☐	☐	History of cancer or a tumor	☐	☐	Any other heart problem
☐	☐	History of radiation	☐	☐	History of blood clots/phlebitis
☐	☐	History of chemotherapy	☐	☐	History of any blood disorder
☐	☐	History of surgery	☐	☐	History of ulcers
☐	☐	Previous hospitalizations	☐	☐	History of intestinal hemorrhage
☐	☐	Diabetes	☐	☐	History of depression
☐	☐	Thyroid disease/problems	☐	☐	History of anxiety disorder
☐	☐	Recent unexplained weight change	☐	☐	History of suicide thought/ attempts
☐	☐	Collagen vascular disease/problems	☐	☐	Kidney disease/problems
☐	☐	Lyme disease	☐	☐	Liver disease/problems
☐	☐	HIV or AIDS	☐	☐	Prostate disease/problems (men)
☐	☐	Hepatitis B	☐	☐	Ovarian/Uterine disease problems(w)
☐	☐	Arthritis	☐	☐	Dizziness or Vertigo
☐	☐	Glaucoma	☐	☐	History of TIA
☐	☐	Asthma	☐	☐	History of Stroke
☐	☐	Emphysema	☐	☐	Loss of consciousness (black out/faint)
☐	☐	Shortness of breath	☐	☐	History of seizures
☐	☐	Chronic cough	☐	☐	Multiple sclerosis
☐	☐	History of tuberculosis	☐	☐	Migraine headache
☐	☐	Angina/chest pain/Irregular heart beat	☐	☐	Chronic headache
☐	☐	Leg pain with walking	☐	☐	Blurred/double vision
☐	☐	Heart murmur	☐	☐	Other neurological problems
☐	☐	History of rheumatic fever	☐	☐	Drug dependency
☐	☐	History of heart attack	☐	☐	Alcohol addiction
☐	☐	Congestive heart failure	☐	☐	Metal fragments in body
☐	☐	High Blood Pressure	☐	☐	**Are you Currently Pregnant?**

Medication History

Yes	No	Are you Taking Medication	Yes	No	Are You Taking Medication
☐	☐	For diabetes	☐	☐	To help you sleep
☐	☐	For a heart problem	☐	☐	To calm your nerves
☐	☐	For high blood pressure	☐	☐	For depression
☐	☐	To reduce body fluids	☐	☐	For pain
☐	☐	To thin the blood	☐	☐	For muscle spasm
☐	☐	For asthma	☐	☐	For bladder control
☐	☐	For bronchitis	☐	☐	Steroids
☐	☐	For another lung problem	☐	☐	Birth Control Pills
☐	☐	For stomach or bowel problems	☐	☐	Chemotherapy
☐	☐	For glaucoma	☐	☐	Other medication not listed

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The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices (the "Notice") is available for your review. This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of Your Health Information:** We may use the information we develop and collect for treatment by our practice or disclose the information to others to who we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcription service, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. **Other Uses and Disclosures:** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights**: You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:

a. You may request restrictions on certain uses and disclosures of your information
b. You may request that you receive your information from us in a certain way
c. You may inspect and copy your medical records
d. You may request an amendment to any record you believe is inaccurate
e. You may request an accounting of disclosures made of your records

4. **Changes to the Notice:** We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.

5. **Complaints:** You may file a complaint to our Privacy Official Dr. Kendra Becker or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

Policy has been made available for me for review.

Signature:_____ Soc. Sec. #

Name:_____ Date:_____

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Please Read, Initial & Sign:

_____ (initial) Our time is precious. Please cancel or reschedule appointments 24 hours in advance (Saturday appointments need to be cancelled 48 hours in advance). Late cancellations and missed appointments will incur an $80 fee.

_____ (initial) Dr Becker does not participate in any insurance plans (except Tricare Standard). Any lab testing denied by your insurance company should be discussed directly with your insurance provider.

_____ (initial) Please secure a PCP. Dr Becker does not perform Primary Care responsibilities.

_____ (initial) Supplements and some lab fees may not be covered under your plan or may be denied by your insurance company. Any fees denied by your insurance company will be your financial responsibility.

_____ (initial) If you need an appointment receipt to submit to your insurance company for reimbursement or for your HSA, please let the front desk know. Please ask for a receipt with EVERY visit. There will be a $1.00 per page charge for replications of receipts at the end of the year. All requests must be in writing, and FWCC has 14 days to produce the documents.

_____ (initial) Please note that all forms filled out **outside** of a scheduled appointment will incur a $20 fee (additional fee for if 3 or more pages) and may take up to 7 (seven) days to complete.

Thank you for understanding,

FWCC

Sign _____Date_____

Print_____

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E-mail Consent Form

Patient Name: _____ E-mail address: _____
Date of Birth: _____ phone number: _____

The Family Wellness Centre of Connecticut offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

RISKS

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

HOW WE WILL USE E-MAIL

1) We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
    a. Questions about prescriptions, use of medical equipment or devices, etc.
    b. Routine follow-up questions
    c. Appointment scheduling
    d. Billing questions
3) All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.
4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
6) If you request, we will e-mail your health information to you or to a third party designated by you.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911. Also, do not use e-mail for urgent problems. If you have an urgent problem, call our office **860-572-7711** or go to an urgent care facility.

GUIDELINES FOR E-MAIL COMMUNICATION

1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2) The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality of e-mail, such as safeguarding your computer password and using screen savers.
8) Inform us of changes in your email address.

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CONSENT

I, _____, am:
(print name)

____ a) an established patient of The Family Wellness Centre of Connecticut

____ b) the legal representative of an established patient,
_____
(print patient's name)

I may want to communicate with The Family Wellness Centre of Connecticut and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that The Family Wellness Centre of Connecticut cannot guarantee the security and confidentiality of e-mail communication. The Family Wellness Centre of Connecticut will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with The Family Wellness Centre of Connecticut by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or The Family Wellness Centre of Connecticut may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising The Family Wellness Centre of Connecticut in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Family Wellness Centre of Connecticut.

_____
(print name)

_____
(signature)

_____
(date)

* Keep the original or top copy in the patient's medical record and give the patient a copy for his/her reference.

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AUTHORIZATION TO RELEASE MY MEDICAL RECORDS

Patient Information:

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Authorization to release medical records to:

- ☐ Myself
- ☐ My spouse: _____
- ☐ Parent: _____
- ☐ Other: _____

These forms can be:

- ☐ Handed to me
- ☐ Faxed to: _____
- ☐ Emailed (must also complete the Email Consent Form)
- ☐ Mailed (postage required)

Signature:_____ Date:_____

Printed medical records are $.65 per page and may also require a minimum of $1.00 postage fee.