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

New Patient ADULT

PATIENT INFORMATION

How did you hear about New Beginnings?

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 #:

Emergency contact: Phone: ( ) Relationship:

Email Address: Marital Status: Single ◉ Married ◯ Widow ◯ Divorced ◯

Employer: Occupation:

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 ◯ AMEX ◯ 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: TO BE FILLED OUT COMPLETELY WITH ATTENTION TO FAMILY HISTORY

What is most important to you about your medical care? (e.g. communication, prevention, wellness)

What specific concerns would you like to address with your new clinician?

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.					

PLEASE LIST ANY ADDITIONAL MEDICATIONS OR SUPPLEMENTS ON THE BACK OF THIS PAGE.

Allergies to medications and other items:

1.	Reaction:
2.	Reaction:
Preferred Pharmacy:	Phone:
Address:	

PERSONAL MEDICAL HISTORY

Have you ever had any problems with the following: (if yes, please explain)

Alcohol or substance abuse:	Metabolism (diabetes, thyroid, etc):
Blood:	Muscle, joint, bones:
Cancer:	Nerves and brain:
Digestion:	Skin and hair:
Ear, nose, throat, eyes:	Sleep:
ER Visits: Type: Date:	Social, mental or emotional health:
Heart or blood vessels:	Kidneys or bladder:
Lungs:	Other:
Surgeries:	

FAMILY MEDICAL HISTORY

Please indicate any family members who have 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 blood cholesterol:	Obesity:	Skin cancer:
HIV:	Parkinson's disease:	Stroke:
Inherited anemias:	Prostate cancer:	Substance Abuse:
Asthma:	Cancer of an unknown cause:	Thyroid:
Autism:	Colon Cancer:	Depression:
Crohn's disease:	Diabetes	Other Cancers:

Any condition that two or more relatives have?

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SOCIAL AND LIFESTYLE HISTORY				
Do you use or have you used tobacco products? (•) Yes or No ( )				
Does anyone routinely smoke in your presence? (•) Yes or No ( )				
Do you use or have you ever used recreational drugs? (•) Yes or No ( )				
How much caffeine do you consume daily?				
Do you have concerns about your diet? (•) Yes or No ( )				
If yes, please explain:				
How often do you exercise?				
HEALTH MAINTENANCE & PREVENTION				
When was the last time you:				
Had a Tetanus booster:				
Had a blood sugar test:				
Had a cholesterol test:				
Had a colon cancer screening:				
Women's Health				
When was your last:	PAP smear:	Mammogram:	Bone Density:	
Pregnancies (#):	Births (#):	Living Children(#):	Miscarriages (#):	Abortions (#):
Men's Health				
When was your last Prostate exam?				

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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.

Patient Signature	Date	Patient Name Printed	
Representative Name		Relationship to Patient	

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FINANCIAL RESPONSIBILITY AGREEMENT

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)