Name_____ Birthdate_____

Reason for visit_____

_____

Room #
Ht_____ Wt_____ T_____
P_____R_____BP_____
O2 Sat_____ CP___ SOB____

Are you in any pain today? Yes or No Where is the pain_____

*********NEW PATIENTS COMPLETE ALL SECTIONS**********

Diagnosis	Yes	Diagnosis	Yes
_____CHECK IF THERE HAS BEEN NO CHANGES SINCE LAST APPOINTMENT (Then go to the next section)			
Allergies (seasonal)		Gout	
Asthma		Thyroid disease	
Anxiety		Heart burn	
Alcoholism		Heart disease	
Anemia		Hepatitis	
Arthritis		HIV	
Blood clot		High blood pressure	
Cancer		High cholesterol	
Crohn's disease		Kidney disease	
Congestive heart failure		Liver disease	
Dementia/memory loss		Lupus	
Depression		Rheumatoid arthritis	
Diabetes		Seizure disorder	
Emphysema/COPD		Sleep apnea	
Eczema		Stroke	
Fibromyalgia		Cataracts	
Fibroids		Glaucoma	

SURGERY HISTORY

Procedure	Year performed	Where performed/Doctor	Procedure	Year performed	Where performed/Doctor
_____CHECK IF THERE HAS BEEN NO CHANGES SINCE LAST APPOINTMENT (Then go to the next section)					
Appendectomy			Joint replacement		
Amputation limb			Cataract removal		
Breast biopsy			Organ removal		
Breast reduction			Stent placement		
Tubal Ligation			Fibroid removal		
Cardiac bypass			Ovary removal		
Gallbladder removal			Vasectomy		
Hernia repair			Weight loss procedures		
Hysterectomy			Carpel tunnel release		

FAMILY HISTORY

Check what applies	High blood pressure	Diabetes	Cancer	Heart disease	Thyroid disorders	Clotting disorder	Kidney disease	Mental health disorder
_____CHECK IF THERE HAS BEEN NO CHANGES SINCE LAST APPOINTMENT (Then go to the next section)								
Mother								
Father								
Sister								
Brother								
Son								
Daughter								
Mom's Mother								
Mom's Father								
Dad's Mother								
Dad's Father								
Aunts/Uncles								

ALL PATIENTS MUST COMPLETE ALL SECTION BELOW THIS POINT.

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? YES OR NO

Allergy	Reaction

PHARMACY NAME_____ LOCATION_____

Medication(s)	Strength taken	How often taken

Specialist Type	Physician's Name	When was your last visit
____CHECK IF YOU DO NOT SEE ANY SPECIALIST		

Answer all questions below	Yes	No	N/A
Did you bring blood pressure or blood glucose logs?			
Did you bring your medications?			
Did you have a fall in the last 12 months?			
Do you have problems holding your urine?			
Do you have problems with erectile dysfunction?			
Did you formerly smoke tobacco?			
Do you currently smoke?	cigarettes	Cigars/pipes	vapes
How much do you smoke a day?	Less than 10	½ pack	1 pack or more
Do you drink any alcohol?			
Do you drink	wine	beer	Liquor/whiskey
How many days do you drink alcohol each week?	1 2 3 4 5 6 7		
Do you want information to help quit?			
Do you use: marijuana cocaine heroin meth or abuse prescription strength medications (Please circle)			
How many days a week?	1 2 3 4 5 6 7		
How many days a week do you exercise	1 2 3 4 5 6 7		

Immunizations	When performed/(month/year)	Where received
Influenza (flu)		
Covid series		
Covid booster		
Pneumonia 13		
Pneumonia20		
Pneumonia 23		
Shingles/Zostavax		
Tdap/Tetanus booster		
Hepatitis B		
HPV		

INSURANCE COMPANIES REQUIRE THIS SCREENING TO BE DONE AT EVERY OFFICE VISIT.

DEPRESSION SCREENING; **In the past 14 days how often have you felt (Place a check in box that applies)**	**none**	**1-6 days**	**7-13 days**	**14 days**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite---being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or thoughts of hurting yourself in someway				

When was your last/have you ever had	**Yes**	**No**	**When performed Month/year**	**Where performed**
Blood work done (within last 6 months)				
Eye exam				
Dental exam				
Colonoscopy/colon cancer screening				
EKG				
Chest x-ray				
Pulmonary function test				
Sleep study				
Prostate screening				
Mammogram screening				
Bone density screening				
Pap smear				
When was your last menstrual cycle? (month/year) _____				

DR. ANGELA OVERSTREET WRIGHT
2607 Commons Blvd. Augusta, GA 30909
Office Phone 706-750-8601 Fax
762-994-1086

I _____ DOB _____ acknowledge I have read the statements below by placing my **initials in the box next to each statement**.

_____ I hereby give Health Done Wright, Inc my consent for medical treatment. I consent to the physician, and/or Nurse Practitioner, or Physician Assistant, and other health care providers or the designee as deemed necessary, to perform reasonable and necessary medical examination and testing to include photographing or digital recording of images for medical purposes. I understand that information obtained through questionnaires, physical examination, and photographing/digital image recordings may be part of the evaluation, examination, and follow-up process, and this information will only be utilized to help the provider determine the appropriate treatment for the condition(s) which has brought me to seek care at this practice. I understand that if additional testing, invasive, or intervention procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s) being performed. This consent for treatment will be valid for as long as I seek healthcare services at Health Done Wright Inc.

_____ I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who may contribute to my healthcare.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

_____ I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

_____ I understand that as part of my care and treatment it may be necessary to share my Protected Health Information with another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

☐ I hereby give my consent for the doctor and staff of HEALTH DONE WRIGHT, INC. to disclose/share my protected health information (PHI) with the following person(s). The person(s), I listed below have an active role in helping me manage my health issues and/or serve as a contact in the case of emergency.
I may revoke my consent in writing except to the extent that the practice has already made disclosure upon my prior consent.

1. Name_____ Relationship_____

   Contact number _____ Emergency Contact __ Yes __ No

2. Name_____ Relationship_____

   Contact number _____ Emergency Contact __ Yes __ No

☐ I acknowledge that Health Done Wright, is not a pain management office. There is no guarantee that pain medicines or other controlled substances issued by another provider will be continued by Dr. Wright at the time of the visit. Dr. Wright relies on information obtained during the physical examination and from diagnostic test and image, to determine the appropriate treatment for your issue. Dr. Wright does not initiate or continue Adult ADD medications.

☐ **I Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))**

- I have the right to review this Practice's Notice of Information practices prior to signing this consent.
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this Practice has already acted in reliance thereon.

☐ I give permission to my healthcare provider to collect and share my pharmacy and health insurer information about my prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date signed _____

Health Done Wright, Inc's Notice of Financial Responsibility for Payment of Office Services

- **HEALTH INSURANCE COVERAGE**: Please provide all medical insurance coverage information including the primary and secondary coverage you may have, before or during check-in. Health Done Wright, Inc will file the medical claims for services received using the insurance information provided. In addition, you must verify and or update your insurance information before each office visit. **If you fail to provide accurate insurance information and the claim is rejected, you will be responsible for paying the bill.** This office **will not refile** claims when you fail to provide accurate information up front. After you have paid the bill, the office will supply you with an itemized statement and the receipt which you can submit to the insurance company to get your money back. Accounts with unpaid balances after **90- days** will be forwarded to collections.
- **COPAYMENTS & DEDUCTIBLE:** Some commercial insurance companies have co-payment requirements that must be collected upfront before **each** office visit. The copayment account is usually found on the front of the insurance card.
- **DEDUCTIBLE:** Some commercial insurance companies have an annual deductible amount patients must reach each year. A deductible is a set amount the patient must pay before the insurance will **pay anything towards** medical bills. Until the deductible is met, patients are responsible for paying all medical bills. Therefore, patients with high deductibles are now required to pay a portion of the office visits **($120) upfront** at the time of check in and we will bill you for the remaining balance. Some patients who have a high deductible may have an employer Health Savings Account (HSA) that put funds on a card that can be used to pay medical expenses/bills. Please check with your HR department to see if your company have HSA. Account with unpaid balances after **90- days** will be forwarded to collections.
- **HEALTH MANAGEMENT ORGANIZATIONS (HMO'S) AND MANAGED CARE ORGANIZATIONS (MCO'S): HMO'S AND MCO'S** Insurance companies sometimes assign patients to a specific primary care doctor. If your insurance card has a doctor's name on it that is not Dr. Angela Wright with 2607 Commons Blvd as the address and 706-750-8601 as the phone number, the insurance will not pay for your office visit at this office. You must call the insurance company customer service number and request for Dr. Wright to be your PCP, and ask for a reference number.
- **OFFICE STATEMENTS**: Health Done Wright, Inc **does not send out** paper statements. All balances are available in the patient portal. You must log into your patient portal monthly to check for and pay your account balances. Accounts with unpaid balances after **90- days** will be forwarded to collections.

- **CREDIT CARD/DEBIT STORED ON YOUR FILE:** Health Done Wright, Inc offer patients the opportunity to leave a credit/debit card on file to pay balances. Your credit card information is entered into a secure field of the electronic health records system. Once entered we can only see the last 4 digits of the card. Health Done Wright, Inc does not process payments without informing you. You will receive a call or a text message about your balance before cards are processed. A (NSF) non-sufficient fund charge of $35 will be imposed on all declined transactions, unless you make good on the payment within 7 business days. Accounts with unpaid balances after **90- days** will be forwarded to collections.
- **PAYMENT PLANS:** If you are experiencing financial difficulties, please call the office to discuss the available payment options. Health Done Wright and Dr. Wright's primary focus is improving your health, but we must get paid for services, so that we can continue to be here to take care of you and others. We will do all we can to work with you to help settle account balances. Accounts with unpaid balances after **90-days** will be forwarded to collections.
- **NO SHOW APPOINTMENTS:** When an appointment is scheduled, it means a specific time slot has been reserved for you and no other patient will be scheduled at that time. Not showing or failing to give 24-hour notice to cancel an appointment does not allow us enough time to fill that slot resulting in an inconvenience for other patients as well as loss of revenue for the office. Therefore, we must charge a **$75 no-show fee.** This fee is not covered by your insurance and is your responsibility. You must pay the fee before any further appointments are scheduled. Accounts with unpaid balances after **90-days** will be forwarded to collections. More than 3 no-shows can result in dismal from the practice

I have read, I understand, and I agree with the above information.

_____ _____

Print Name Birth Date

_____ _____

Signature Today's Date

$75 No-Show/Late Cancellation Fees

To provide you and all patients of Dr. Angela O. Wright the best possible care, a minimum of 24-hour notice is required to cancel or reschedule your appointments. I understand the importance of notifying Health Done Wright, Inc., at least 24-hours prior to my scheduled appointment that I am not able to keep my appointment. If I do not give a 24-hour notice, I will be charged a $75 no-show fee for missing the appointment. I understand this fee is not covered by my insurance and it is my responsibility to pay this fee. I also acknowledge no future appointment will be made until I have paid this fee and that it is Health Done Wright's policy to dismiss patients who have 3-no-show appointments.

Signature _____Date _____

Credit/Debit Card on file

I have read the financial responsibility form and understand that my insurance plan may require me to pay a co-payment and/or meet certain deductible amounts before the insurance will pay anything towards my medical bills. Therefore, I am requesting to have my card information stored securely in the electronic medical records and be used for payment of services (co-pays & fees) and I will be notified before my card is processed. I understand that I may revoke this agreement at any time by providing a request in writing to the office. I also understand that when medical services with Health Done Wright, Inc end, this agreement also ends. Please present your credit/debit card to the front office staff to enter in the system. They will ask you to remain at the window while the information is entered and immediately give the card back to you. Once entered only the last 4 digits of your card can be seen.)

Name _____

Signature _____ Date _____

Health Done Wright, Inc

Release of Medical Information Authorization Form

(Print Name) _____ (Date of Birth) _____

Consent to the release of my medical records to

Health Done Wright, Inc. office of Dr. Angela Overstreet Wright
2607 Commons Blvd, Augusta GA 30909
Office Phone [706]-750-8601 Records can be mailed to the address above or Fax to [866]-610-4814.

I understand the information may include reference to psychiatric/psychological care, drug and alcohol abuse information, and/or result of test for all infectious diseases including HIV/AIDS. I understand that I have a right to revoke this authorization at any time. I understand that if I wish to revoke this authorization I must do so in writing and present my written cancellation/revocation to Dr. Angela Overstreet Wright or the office manager. I understand the cancellation/revocation is only applicable for the date submitted and does not apply to information that has already been released in response to this authorization.

_____ _____

Signature Date

This section to be completed by the office staff

The patient above has consent for our office to retrieve a copy of their medical records from your office.

Name of healthcare provider or facility _____

Phone _____ Fax _____

Please share the following information:

_____

____Office notes including H&P _____
____Lab Results for _____
____X-Ray images of _____
____Procedure Report for _____
____Hospital Notes from _____
____Emergency Notes from _____
____Immunization Records _____
____Medication List _____
____Psychotherapy Notes _____
____ Other _____