**Trilogy Health & Wellness Center**

510 Swanson Road, Tyrone, GA 30290 770.964.5230 [www.trilogywellness.com](http://www.trilogywellness.com)

PATIENT INFORMATION

**PATIENT INFORMATION**

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

*Last First*

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male\_\_\_ Female:\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single\_\_\_ Married\_\_\_ Divorced\_\_\_ Widowed\_\_\_ Minor\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like a phone reminder? Yes\_\_\_ No\_\_\_ Would you like an email reminder? Yes\_\_\_ No\_\_\_

Can we leave a voicemail message? Yes\_\_\_ No\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to our office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT INFORMATION

**ACCIDENT INFORMATION**

Is this visit due to an accident? Yes\_\_\_ No\_\_\_ If Yes, what type? Auto\_\_\_ Work\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has it been reported? Yes\_\_\_ No\_\_\_ If Yes, to whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed the Trilogy AA (Auto Accident) Form?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please ask front desk for a copy)

PATIENT INFORMATION

**INSURANCE INFORMATION**

Do you have health insurance? Yes\_\_\_ No\_\_\_ Name of Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have secondary insurance? Yes\_\_\_ No\_\_\_ Name of Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it an HMO? Yes\_\_\_ No\_\_\_

Name of the person who is the policy holder of this insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if other than self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Services Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT INFORMATION

**PATIENT CONSENT AND CARE RELEASE**

I certify that I (or my dependent) have insurance with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases of underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

Patient Signature (X):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check to indicate if you are *currently* experiencing any of the following conditions:**

\_\_Neck Pain/Stiffness \_\_Pins/Needles in Arms \_\_Light Bothers Eyes \_\_Sudden Weight Loss \_\_Nausea

\_\_Back Pain/Stiffness \_\_Pins/Needles in Legs \_\_Depression \_\_Loss of Taste \_\_Cold Feet

\_\_Arm/Hand Pain \_\_Fatigue \_\_Nervousness \_\_Loss of Memory \_\_Chest Pain

\_\_Leg/Knee Pain \_\_Sleeping Difficulties \_\_Tension \_\_Jaw Problems \_\_Fever

\_\_Headaches \_\_Loss of Smell \_\_Cold Sweats \_\_Constipation \_\_Fainting

\_\_Dizziness \_\_Allergies \_\_Stomach Problems \_\_Shortness of Breath \_\_Hypertension

\_\_Asthma \_\_Blurred Vision \_\_Night Pain \_\_Bowel/Bladder Changes

**Please check to indicate if you have ever had any of the following:**

\_\_Aids/HIV \_\_Cataracts \_\_Hernia \_\_Osteoporosis \_\_Suicide Attempt

\_\_Alcoholism \_\_Chemical Dependency \_\_Herniated Disc \_\_Pacemaker \_\_Thyroid Problems

\_\_Allergy Shots \_\_Chicken Pox \_\_Herpes \_\_Parkinson’s Disease \_\_Tonsillitis

\_\_Anemia \_\_Diabetes \_\_High Cholesterol \_\_Pinched Nerve \_\_Tuberculosis

\_\_Anorexia \_\_Emphysema \_\_Kidney Disease \_\_Pneumonia \_\_Tumors/Growths

\_\_Appendicitis \_\_Epilepsy \_\_Liver Disease \_\_Polio \_\_Typhoid Fever

\_\_Arthritis \_\_Fracture \_\_Lung Diseas \_\_Prostate Problems \_\_Ulcers

\_\_Asthma \_\_Glaucoma \_\_Measles \_\_Prosthesis \_\_Vaginal Infections

\_\_Bleeding Disorder \_\_Goiter \_\_Migraines \_\_Psychiatric Care \_\_Venereal Diseases

\_\_Breast Lump \_\_Gonorrhea \_\_Miscarriage \_\_Rheumatoid Arthritis \_\_Lung Disease

\_\_Bronchitis \_\_Gout \_\_Mononucleosis \_\_Rheumatic Fever \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Bulimia \_\_Heart Disease \_\_Multiple Sclerosis \_\_Scarlet Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Cancer \_\_Hepatitis \_\_Mumps \_\_Stroke

Are you currently under drug and/or medical care? \_\_No \_\_Yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **ALL** Medications and the respective doses you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medication allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Environmental allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any supplements (vitamins, herbs, minerals) you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of the following conditions? (Indicate family member including parents, grandparents, & siblings)

\_\_Heart Disease Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Diabetes Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Cancer Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Arthritis Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise: \_\_Frequently \_\_Moderately \_\_Occasionally \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your work activities mostly involve: \_\_Sitting \_\_Standing \_\_Light Labor \_\_Heavy Labor

Do you sleep on your: \_\_Back \_\_Side \_\_Stomach Do you use cervical pillows: \_\_Yes \_\_No

What is your daily /weekly intake of the following:

Caffeine\_\_\_\_\_\_\_\_\_cups/day Alcohol\_\_\_\_\_\_\_\_\_\_\_\_drinks/week Cigarettes\_\_\_\_\_\_\_\_\_\_\_\_packs/day

Drugs\_\_\_\_\_\_\_\_\_\_\_ Water\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Salty Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sugary Foods\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date

 **Welcome to Trilogy Health & Wellness Center**

**AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPPA)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Trilogy Health & Wellness Center, doctors and staff: to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations. (This includes any insurance company’s pertaining to my eyecare.)

Name of the persons I authorize release of information to **(Another doctor’s office or family member) you may revoke at any time. (If the person is not listed we cannot disclose or speak with them)**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*NOTICNOTICE OF PRIVACY Acknowledgement of Receipt of Privacy Notice.**

The Health Insurance Portability and Accountability Act **(HIPPA**) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at Trilogy Health & Wellness Center, we are committed to practicing the privacy of that information. Because of the commitment, we must obtain your special authorization before me may use or disclose your protected health information to any party. This office will only use and disclose personal health information to permit the office to perform its administrative duties, provide health care services, process benefit claims, process insurance claims, or email per patient authorization.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been presented a copy of the HIPPA privacy act, I have read it and understand the content. I know that at any time I can request my own personal copy of the form.

By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**NO-SHOW and CANCELLATION POLICY**

The practice has a policy of charging a fee for missing an appointment of canceling with less than a 24 hour notice. The fee is $35.00. Obviously, acute health emergencies and family crisis sometimes occur. However, appointments missed or cancelled for convenience, having been forgotten, or due to personal last-minute scheduling conflict will be your responsibility. Thank you for your cooperation and understanding.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date

**FINANCIAL POLICY**

Thank you for choosing Trilogy Health & Wellness Center as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all of your medical needs are met, our billing department will be available to discuss our fees and this policy with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician. Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, it is the policy of Trilogy Health & Wellness Center to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

**(PLEASE READ AND INITIAL THE FOLLOWING)**

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance carrier regarding deductibles, copayments, covered charges, secondary information and "usual and customary" charges. As your medical provider, we only supply factual information to facilitate claim processing.

Initial

\_\_\_\_\_\_

2. Fees for services, which include unpaid balances, deductibles, and copayments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

Initial

\_\_\_\_\_

3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Trilogy Health & Wellness Center, you recognize an obligation to promptly remit payment to Trilogy Health & Wellness Center.

Initial

\_\_\_\_\_

4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Trilogy Health & Wellness Center, I will be responsible for all cost of collecting money owed, including court costs, collection agency fees, and attorney fees.

Initial

\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**PAYMENT OPTIONS**

1. **Payment at the time of service.** We accept cash, check, Visa, MasterCard, Discover, and American Express.

2. **Insurance.** We will bill your insurance. You will be required to pay the co-pay and/or coinsurance portion upfront. You will be balanced billed when insurance pays. Our terms are net 30 days.

3. **Injury.** We are happy to work with you during your Personal Injury (PI). We will accept you as a patient only with a lien from your attorney stating, once your claim is settled, we will receive immediate payment. It is your responsibility to obtain this letter from your attorney.

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Signature of Patient or Legal Representative Date

**Please note**: Services may vary depending on the doctor’s recommendation and your progress. Supplements are not covered by insurance and must be paid at the time of your purchase. Insurance claims will be filed at the time services are rendered. Additional services may be recommended that are not included in your protocol. These services are to be paid at the time of service.



**TRILOGY HEALTH & WELLNESS CENTER**

A WORD TO OUR PATIENTS ABOUT THE ANNUAL WELLNESS VISIT

Dear Patient,

We want you to receive wellness care – health care that may lower your risk of illness or injury. The Affordable Care Act (ACA) covers some wellness care and important preventive services. We want you to know how to help avoid illness and improve your health.

The term “physical” is often used to describe wellness care. But ACA does not cover a traditional, head-to-toe physical. ACA does cover a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services, depending on your age:

* Screenings to detect depression, risk for falling and many cancer screenings, including mammograms and colonoscopies,
* A limited physical exam to check your blood pressure, weight, vision and other things depending on our age, gender and level of activity, including well-baby and well-child visits until age 21,
* Tests for diabetes and cholesterol,
* Recommendations for other wellness services and healthy lifestyle changes,
* Routine vaccinations are covered; although not available here at Trilogy, we can refer you as appropriate.

Before your appointment, our staff will ask you some questions about your health and may ask you to fill out a form.

***A wellness visit does not deal with new or existing health problems.*** *That would be a* ***separate service*** *and requires a longer appointment. Please let our scheduling staff know if you need the doctor’s help with a health problem, a medication refill or something else. We may need to schedule a separate appointment.* ***A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.***

We hope to help you get the most from your ACA wellness benefits. Please contact us with any questions.

A list of covered services is available for your review.

For further information, please go to healthcare.gov.

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Signature of Patient or Legal Representative Date