HEALING HANDS
MEDICAL CLINIC

Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: _____ Marital Status: _____

SSN: _____ - ____ - _____ Driver License Number: _____ State: _____

Address: _____

City: _____ State: _____ Zip: _____

Billing Address: Check if same as above: ☐

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____

Email Address: _____

Preferred Method of Contact: Mail Phone/Text Email

Emergency Contact: _____ Relationship: _____

Phone Number: (_____) _____ - _____

Guarantor Information: (Please list person's name responsible for bill – Full legal name)

Relationship of Guarantor to Patient: ☐ Self ☐ Spouse ☐ Parent / Guardian ☐ Other: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: _____ Marital Status: _____

SSN: _____ - ____ - _____ Driver License Number: _____ State: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical History

- ☐ Anemia
- ☐ Asthma
- ☐ Pneumonia
- ☐ Cancer (any)
- ☐ Stroke / CVA / TIA
- ☐ Thyroid Condition
- ☐ Bone / Joint Infections
- ☐ Seizures / Epilepsy
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Chronic Headaches
- ☐ TB / HIV / Hepatitis A/B/C
- ☐ Chest Pain or Angina
- ☐ High / Low Blood Pressure
- ☐ Lung Disease / COPD / ARDS
- ☐ Bladder, Urinary, Kidney Disease
- ☐ Osteo / Rheumatoid Arthritis
- ☐ Congestive Heart Failure
- ☐ Visual or Hearing Impairments
- ☐ Back Pain
- ☐ GI Disease
- ☐ Vascular / Circulation Problem
- ☐ Depression / Anxiety / Panic
- ☐ Neurological Disease
- ☐ Other: (list below)

Other: _____

_____

Surgeries (with Dates): _____

_____

_____

Allergies: _____

_____

_____

Medications:

Medication	Dosage	Frequency (How Often)
1.		
2.		
3.		
4.		
5.		

***For additional space, please use the medication page in the back of this packet**

Over The Counter Medications / Supplements:

Medication / Supplement	Dosage	Frequency (How Often)
1.		
2.		
3.		
4.		
5.		

***For additional space, please use the medication page in the back of this packet**

Tobacco use: ☐ **Cigarettes** ☐ **E-cigarettes** ☐ **Chewing/Pouch** **How Often / Packs a Day: _____**

Alcohol use: ☐ **Y** ☐ **N** **How Often: (**Daily, Weekly, Monthly, Socially) _____

Drug use: ☐ **Y** ☐ **N** **How Often: (**Daily, Weekly, Monthly, Socially) _____

HEALING HANDS
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Patient Registration, Disclosures & Consents

Authorization To Release Non-Public Personal Information:

I hereby authorize Healing Hands Medical Clinic or the physician, Nurse Practitioner, individually representative to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. All information otherwise will be kept confidential and will not be released without permission.

Initial _____

Authorization To Mail, Call, or E-Mail:

I certify that I understand the privacy risks of mail, phone calls, and email. I hereby authorize a Healing Hands Medical Clinic representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Healing Hands Medical Clinic to that effect in writing.

Initial _____

Lab/X-Ray/Diagnostic Services:

I certify that I understand that I may Receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I understand if I am receiving these services in the clinic, I will be obligated to pay for them at the time of service rendered. Healing Hands Medical Clinic may provide a receipt for you to submit to your insurance or you may schedule services outside of the clinic.

Initial _____

Consent to Treatment via Telehealth:

I hereby consent to the evaluation, testing, and treatment as directed by Healing Hands Medical Clinic physician, nurse practitioner or his/her designee via telehealth. I hereby understand that I must be an established patient and have seen a provider within the last year at the time of visit. I understand that the provider is limited to what they can do, without physically seeing me. I understand the provider has the right to not see me via telehealth if they feel the visit is inappropriate.

Initial _____

Consent to Treatment:

I hereby consent to the evaluation, testing, and treatment as directed by Healing Hands Medical Clinic physician, nurse practitioner or his/her designee. In an emergency, I understand the provider has the right to call 911 for emergency transport to a local Emergency Department. All fees associated with the transport and Emergency Department are the patient's responsibility not the responsibility of Healing Hands Medical Clinic.

Initial _____

Patient name: _____

Legal Guardian Name: _____ Relationship: _____

Signature: _____ Date: _____

HEALING HANDS
MEDICAL CLINIC

Consent for Payment

I hereby understand that all payment information is true and accurate. I hereby understand that all payments are due at the time of services. I, as legal guardianship of all minors being seen under my care that are seen at Healing Hands Medical Clinic understand, I am responsible for all financial charges occurred by the minor. You have the right to request an estimate of services before services are rendered. You must request that estimate in advance. I understand Healing Hands Medical Clinic has the right to use my personal information to try and receive payments. I understand if I am unable to pay for services, I will notify Healing Hands Medical Clinic before treatment and will work out an arrangement in writing.

Initial _____

Release of Liability for Non-Prescription / Non-Regulated Products.

Release of Liability and Medical Disclaimer for all products sold through Healing Hands Medical Clinic: I hereby understand that all supplemental products that are sold through Healing Hands Medical Clinic are optional, and as such take full liability. Supplemental products are not considered a cure, treatment, or prevention of any disease or medical issue. Due to some of these products containing natural/organic ingredients such as: essential oils, butters from natural nuts, seeds and fruit, there may be a chance of an allergic reaction. Please check the ingredients list for any allergies. If any sensitivity or irritation occurs, please immediately discontinue use, and contact your medical provider for any questions or concerns. If you have a severe allergic reaction, call 911 or go to the closest emergency department. In case of pregnancy, please check with your OB or Doctor prior to use.

Initial _____

Patient name: _____

Legal Guardian Name: _____ Relationship: _____

Signature: _____ Date: _____

Medication / Supplement	Dosage	Frequency (How Often)
1.		
2.		
3.		
4.		
5.		
6.		
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