COMPLETE EMBODIMENT
WELLNESS

WELCOME TO OUR PRACTICE

We would like to take this opportunity to welcome you as a patient of Complete Embodiment Wellness, Brittany Aitchison, FNP-C.

The providers and staff of Complete Embodiment Wellness would like to thank you for entrusting us to partner with you on your healthcare needs. Our Mission is to collaborate with our patients to accomplish a common goal of excellence in healthcare and service.

In order to accomplish this mission, we have established policies and procedures to keep you well informed, actively involved with our staff members and help you come prepared for your appointment.

OFFICE HOURS: Our clinic is open Monday through Thursday from 8:00am to 4:00pm and closed on Friday's. We close for lunch between 11:30-12:30 PM.

AFTER HOURS CARE: If you have a medical emergency while the office is closed, please call 911 or go to your nearest urgent care center or hospital emergency room. Our providers operate a clinic only but have arranged for hospital physicians at both St. Alphonsus and St. Luke's to admit and care for our patients when necessary.

PRESCRIPTION REFILLS: We ask that you call your pharmacist to initiate a refill of your medication. Mast pharmacies appreciate a 72-hour notification. This gives the pharmacist time to prepare your prescription accurately and contact your healthcare provider with any questions they may have. Please make sure we have a current record of your preferred pharmacy and insurance coverage. There are also standards of care that we follow regarding prescription.

refills and lab tests. At a minimum, when you are prescribed a medication long term, it is important to have annual lab tests to confirm the medication is still effective and you are not experiencing side effects from the medication. Some medications require mare frequent testing.

APPOINTMENTS: You may schedule an appointment by calling the office and speaking with any one of our support staff. You may also schedule a follow-up appointment while you are checking out after seeing one of our providers. Diagnosis and treatment plans cannot be appropriately made over the telephone or by emailing, therefore we ask that you schedule an appointment far an office visit and bring all questions with you to your appointment. As a courtesy to other patients, as well as our providers, we ask that you give our staff a 24 hour notice if you must cancel or reschedule an appointment. Any appointment not kept without cancelling is considered a No Show. If a patient accumulates 3 No Shows within a year, we may ask you to make other arrangements for your healthcare.

PREVENTATIVE CARE: Most insurance plans carry wellness and preventative care benefits. We suggest you became familiar with the coverage of your wellness plan and even print a copy of the benefits that are covered and bring them with you to your appointment. Then we can help you receive the benefits of the plan without incurring unexpected casts far tests not covered. Unfortunately, we can never guarantee coverage from your insurer, but will be happy to provide necessary documentation required from your provider.

Initials ______________ Date______________

COMPLETE EMBODIMENT
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BILLING AND INSURANCE

We have provider contracts with several insurance carriers. If you are insured through a carrier that we are in network with, we will bill on your behalf We ask that you please pay your copay and coinsurance at the time of service. If we are not an in-network provider for your insurance carrier, we will be happy to bill your insurer. We ask that you pay for your services at the time of service, with the understanding that you will be reimbursed for covered services directly from your insurance company.

As a new patient, if your deductible hasn't been met and extensive lab is necessary, we require a deposit of up to $250 toward diagnostic testing. Any balance can be paid over a 60-day period.

We recognize that at times people experience financial hardships. Our billing manager is here to work with you on a financial agreement for making monthly payments if the need arises. It is important to stay in contact with our staff and keep your account current. Good communication helps you remain informed on any balances and allows our billing staff to work with you more efficiently.

Unfortunately, there are times when we must turn delinquent accounts over to a third-party collection service. Once that happens, we can no longer honor any financial agreements that have been made and we find it necessary to release the patient from our care.

CASH PAY: Because not all patients carry health insurance, we ask that you inform our front office staff when you will be paying cash and there will be no insurance billing involved. We can provide you with information on saving money if paying at the time of service.

We hope that communicating our office policies with you will allow us to maintain a vibrant provider/ patient relationship.

SIGNATURE: ____ DATE: ______________

COMPLETE EMBODIMENT
WELLNESS

DEMOGRAPHIC INFORMATION

Patient: ______________________________
(Last) *(First)* *(MI)*

Date of Birth ______________ *Gender:* *M* *F* *SSN:* ______________

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow

Preferred Language
- ☐ Unspecified
- ☐ English
- ☐ Spanish
- ☐ Other: __________

Race
- ☐ Unspecified
- ☐ Caucasian
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native American or other Pacific Islander
- ☐ Other

Ethnicity
- ☐ Unspecified
- ☐ Hispanic or Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

How did you hear about us? ______________________________

Preferred Pharmacy: ______________ *Location:* ______________ *Phone:* ______________

Employer: ______________ *City/State:* ______________ *Phone:* ______________

CONTACT INFORMATION

Address: ______________________________
(Street) *(City)* *(State)* *(ZIP)*

Home: ______________ *Mobile:* ______________ *Other:* ______________

Email: ______________ *Preferred Contact:* *Email* *Phone* *Letter* *Email*

Emergency Contact and/or Guarantor: ______________ *Relation:* ______________

Home: ______________ *Mobile:* ______________ *Other:* ______________

BILLING INFORMATION

Primary Insurance: ______________ *Policy Number:* ______________

Policy Holder: ______________ *Policy Holder's Date of Birth:* ______________

Secondary Insurance: ______________ *Policy Number:* ______________

Policy Holder: ______________ *Policy Holder's Date of Birth:* ______________

PLEASE READ AND INITIAL EACH STATEMENT

Assignment of Benefits: *I hereby assign all applicable insurance benefits and direct that all payment be made directly to Complete Embodiment Wellness for services provided during my visit.* ________

Release of Information: *I authorize Complete Embodiment Wellness to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care.* ________

Financial Responsibility: *I have read and understand the full financial policy. ___________ I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collection agency. I will be responsible for the fees assessed by the collection's agency. ________*

Appointments: *I understand that if I do not notify Complete Embodiment Wellness of a cancellation of my appointment at least 24 hours prior to the scheduled appointment, on my second occurrence, I may be assessed a fee and/or dismissed from the practice for multiple occurrences. _______*

Treatment Authorization: *I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at Complete Embodiment Wellness. I authorize a copy of this document to be used in lieu of the original. _________*

HIPPA Acknowledgement: *I have been offered a copy of the HIPPA privacy policies from Complete Embodiment Wellness. ________*

Advanced Directive: *If I have an Advanced Directive, I have given a copy of it to Complete Embodiment Wellness to keep on file. ________*

Authorization to Share Account Related Information: *I hereby authorize Complete Embodiment Wellness to release protected health information to the following persons, to expire on the date listed.*

Name: ____ Expiration Date:___________ Relationship to Patient:____________
Name: ____ Expiration Date:___________ Relationship to Patient:____________
Name: ____ Expiration Date:___________ Relationship to Patient:____________
Name: ____ Expiration Date:___________ Relationship to Patient:____________

____ ________________________

Signature of Patient or Legal Guardian ***Date Signed***

MEDICAL HISTORY QUESTIONNAIRE – PLEASE UPDATE AT EACH VISIT

Patient: ______________________________ *Date of Birth:*______________________

*Do you exercise NO YES (Type/How often)?*______________ *Spouses Name/Occupation:*______________________

Use illicit drugs? NO YES Type/How often? ______________ *Drink alcohol? NO YES How much/often:*______________

Use Tobacco? NO YES Type/How Often? ______________ *How many caffeinated drinks do you have in a day?* __________

CURRENT MEDICATIONS (PLEASE LIST MEDICATION AND DOSAGES, IF YOU HAVE A LIST PLEASE NOTE "SEE LIST")

For current patients, have there been any medication changes since your last visit? ☐*Yes* ☐ *No*

Name: ______________________*Dose:* ____________*Reason:* ________________ *Please continue med list*

Name: ______________________*Dose:* ____________*Reason:* ________________ *on the last page…*

ALLERGIES (MEDICATIONS, ENVIRONMENTAL, FOOD, ETC)

For current patients, have you encountered any new allergies since your last visit? ☐*Yes* ☐ *No*

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

MEDICAL AND SURGICAL HISTORY (CIRCLE ALL THAT APPLY AND/OR FILL IN THE BLANKS AS APPROPRIATE)

For current patients, has anything changed since your last visit? ☐*Yes* ☐*No*

MEDICAL

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bipolar
Cancer
Heart Problems
Depression
Diabetes
Heart Disease
High Blood Pressure
High Cholesterol
Hyperthyroidism
Hypothyroidism
Seizures
Stroke (TIA/ "Mini")
____
____
____
____

SURGICAL

***Please list Year**:*

Appendix
Gallbladder
Heart Bypass
Hip Replacement
Hysterectomy
Knee Replacement
Cesarean Section
Hysterectomy
Tonsils Removed
Hernia Repair
____
____
____
____
____

HOSPITALIZATION

Year: __________*Reason:* ______________________________ *Where:* ____________________

Year: __________*Reason:* ______________________________ *Where:* ____________________

Year: __________*Reason:* ______________________________ *Where:* ____________________

MEDICAL HISTORY QUESTIONNAIRE – PLEASE UPDATE AT EACH VISIT

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY AND/OR FILL IN THE BLANKS AS APPROPRIATE)

For current patients, has anything changed since your last visit? ☐*Yes* ☐*No*

***Mother**: Living Unknown Deceased: (Age/Cause): ____________________*

***Father**: Living Unknown Deceased: (Age/Cause): ____________________*

Number of siblings?______ Number Living?_______ Medical Conditions?____________________

MATERNAL

Cancer: (Type): ____________________ Depression Diabetes

Heart Attack(s) High Blood Pressure High Cholesterol Open Heart Surgery Psychiatric Disorders

Stroke(s) Thyroid Disease ____________ ____________ ____________

PATERNAL

Cancer: (Type): ____________________ Depression Diabetes

Heart Attack(s) High Blood Pressure High Cholesterol Open Heart Surgery Psychiatric Disorders

Stroke(s) Thyroid Disease ____________ ____________ ____________

SOCIAL HISTORY

Do you have a religious/medical restriction? __________If yes, please list____________________

Caffeine intake: ☐ *None* ☐ *Coffee/Tea _______cups/day* ☐ *Soda _______cups/day*

Diet: ☐ *Good* ☐ *Fair* ☐ *Poor How many meals per week outside of home? _______*

Alcohol (drinks per week): _______ Type: ☐ *Beer* ☐ *Wine* ☐ *Liquor* ☐ *Mixed*

Smoking: ☐ *Pipe* ☐ *Cigarettes* ☐ *Chewing Tobacco* ☐ *Vaping* ☐ *Former Smoker* ☐ *Non Smoker*

Amount smoked/used per day: _______ Year Quit: _______

Recreational Drug Use: ☐*Yes* ☐ *No Type: ____________________Frequency: _______per day/week*

PREVIOUS DIAGNOSTIC/VACCINES

Last Colonoscopy: ____________ Normal/Abnormal: ____________Place:

Last Mammogram: ____________ Normal/Abnormal: ____________Place:

Last PSA: ____________ Normal/Abnormal: ____________

Influenza Vaccine: ____________ When: ____________Place:

Covid Vaccine: ____________ When & Which one: ____________ Booster, when & which one:

Shingles Vaccine: ____________ When: ____________Place:

Dexa (Bone Density Scan): ____________ When: ____________Place:

Signature:______________________________Date:____________

MEDICAL HISTORY QUESTIONNAIRE – PLEASE UPDATE AT EACH VISIT

CURRENT MEDICATIONS CONTINUED

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

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Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Name: ________________________________ *Dose:* ________________ *Reason:* ________________________

Signature: ____ *Date:* ______________________