REGISTRATION FORM

(Please Print)

Today's date:	Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box):

☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Facebook ☐ Other:

Other family members seen here:

Email Address:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined	Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Declined

BILLING AND INSURANCE INFORMATION

Please give your insurance card to the receptionist.	☐ Check here if information is the same as patient

Name of person responsible for bill:	Birth date:	Address (if different):	Home phone no.

Is this person a patient here? ☐ Yes ☐ No	Social Security no.:

Responsible Party's Email Address:

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance?

☐ Yes ☐ No

Insurance Company:			Insurance Co. Phone #:	
Subscriber ID (Policy #):			Group ID	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Effective Date:	Co-payment amount: $
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:				
Name of secondary insurance (if applicable):	Subscriber's name:		Subscriber ID (Policy #):	Group ID:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:				

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no:	Work phone no.:
Street address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize WILLOW MEDICAL, LLC. or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

Patient's Name:	Date of Birth:	Gender: ☐ M ☐ F

MEDICATIONS

List all prescriptions and over-the-counter medications, herbs and vitamins you take on a regular basis.

Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:
Medication:	Dose:	Frequency:

ALLERGIES

List the names of any medication, food or environmental allergies and your reactions.

Name:	Reaction:
Name:	Reaction:
Name:	Reaction:

MEDICAL HISTORY

Check the items that apply to you.

☐ No Medical Problems	☐ Abnormal pap	☐ Alcohol/substance abuse	☐ Allergies / Hay Fever	☐ Asthma
☐ Bleeding Disorder	☐ Blood Clot	☐ Cancer	☐ Diabetes or Abnormal Blood Sugar	☐ Headaches
☐ Heart Disease or other Heart Problems	☐ Hepatitis or Other Liver Problem	☐ High Blood Pressure	☐ Intestinal Problems	☐ Migraine
☐ Psychological Problems	☐ Seizures	☐ Sexually Transmitted Disease	☐ Skin Disorder	☐ Thyroid Disorder
☐ TB / Tuberculosis	☐ Ulcer	☐ Urinary Tract Problems	☐ Other:	

SURGICAL, HOSPITALIZATION AND TRAUMA HISTORY

Check the items that apply to you.

☐ None	☐ Appendectomy	☐ Back Surgery	☐ Brain Surgery	☐ Cholecystecomy
☐ C-Section	☐ Eye Surgery	☐ Fusion of back or neck	☐ Hernia Surgery	☐ Heart surgery, cath or stenting
☐ Hip Surgery	☐ Hysterectomy	☐ Knee Surgery	☐ Lung Surgery	☐ Surgery to wrist or hand
☐ Prostate Surgery	☐ Shoulder Surgery	☐ Spine Surgery	☐ Tonsilectomy	☐ Surgery to bowel, spleen or other internal organ
☐ Tubal Ligation	☐ Vascular Surgery	☐ Vasectomy	☐ Mastectomy	Other:

FAMILY HEALTH HISTORY

Check the items that apply to you.

FATHER'S SIDE:

☐ None	☐ Alcoholism	☐ Asthma	☐ Bleeding Disorders	☐ Blood cloths
☐ Dementia / Alzheimer's	☐ Diabetes	☐ Drug Addiction	☐ Heart Disease	☐ High Blood Pressure
☐ Psychological or Psychiatric Problems	☐ Rheumatoid Arthritis or other Autoimmune Disease	☐ Stroke	☐ Other:	

MOTHER'S SIDE:

☐ None	☐ Alcoholism	☐ Asthma	☐ Bleeding Disorders	☐ Blood cloths
☐ Dementia / Alzheimer's	☐ Diabetes	☐ Drug Addiction	☐ Heart Disease	☐ High Blood Pressure
☐ Psychological or Psychiatric Problems	☐ Rheumatoid Arthritis or other Autoimmune Disease	☐ Stroke	☐ Other:	

SOCIAL HISTORY

Complete the items that apply to you.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:

Number of Children:		Ages of Children:		Highest Education Level Completed: ☐ Current student (minor child) ☐ Completed 7th-11th Grade ☐ High school Diploma ☐ GED ☐ Some College ☐ Associates Degree ☐ Bachelor's Degree ☐ Graduate Degree

Are you sexually active? ☐ Yes ☐ No

Birth Control Method: ☐ Birth Control Pill ☐ Condoms ☐ IUD ☐ Depo Provera ☐ Other:

Have you ever smoked? ☐ Yes ☐ No

If yes, complete/check all that apply:
☐ Smoke _____ cigarettes per day
☐ Use smokeless tobacco
☐ No longer smoke but smoked _____ cigarettes per day for ____ yrs ☐ Cigarettes/Cigar/pipe smoked inside the house

Alcohol Use:
☐ None
☐ Occasional: _____ drinks per week
☐ Daily: _____ drinks per day

Recreational Drug Use:
☐ Never used
☐ Used drugs in the past: _____ ☐ Use drugs currently: _____

Exercise Habits:
☐ Never exercise
☐ Occasional exercise: ____ hours per week
☐ Regular exercise: _____ hours per week

Type of exercise:
☐ Running ☐ Walking ☐ Bicycling ☐ Aerobics ☐ Weight Lifting ☐ Yoga ☐ Other: _____

List your recent travel locations outside the United States: _____

REVIEW OF SYSTEMS

Check the items that apply to you.

GENERAL SYMPTOMS: ☐ None ☐ Fever ☐ Fatigue ☐ Unusual weight change ☐ Other:

HEAD: ☐ None ☐ Frequent headaches ☐ Pain jaw with chewing ☐ Facial pain or numbness ☐ Other:

EYES: None Vision changes Eye pain Double vision Other:

EARS: None Hearing loss Ringing in ears Other:

NOSE: None Change in smell Post Nasal drainage Sinus problems Other:

THROAT & MOUTH: None Voice Changes Taste Disturbances Mouth sores Dental problems Other:

CARDIOVASCULAR: None Chest pain Palpitations Swelling in ankles/feet Pain in legs with walking Other:

RESPIRATORY: None Wheezing Prolonged cough Night sweats Coughing up blood Abnormal chest x-ray Other:

GASTROINTESTINAL: None Difficulty swallowing Abdominal pain Blood in stools Change in bowel habits Incontinence Other:

GENITOURINARY: None Painful urination Urgency Frequency Blood in urine Prostate problems Change in urine stream Impotence Other:

MUSCULOSKELETAL: None Join stiffness Joint pain Bone deformities Muscle pain Back pain Other:

SKIN/HAIR/NAILS: None Rashes New or changing skin lesions Persistent rash Unwanted hair growth Hair problems Other:

NEUROLOGIC: None Frequent headaches Insomnia Dizziness or imbalance Numbness Fainting Uncontrolled movements Episodic vision loss Other:

PSYCHIATRIC HISTORY: None Depression Anxiety Irritability Recurrent bad thoughts Hallucinations Other:

ENDOCRINE: None Intolerance to heat or cold Changes in sex drive Menstrual problems Other:

BLOOD: None Easy bleeding or bruising Anemia Other:

LYMPH: None Unexplained swollen areas Other:

ALLERGIC / IMMUNOLOGIC: None Seasonal allergies Hay fever symptoms Itching Frequent Infections
Other:

CONSENT FOR MEDICAL TREATMENT

I am the patient or the patient's duly authorized representative. I do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatment regimens deemed necessary by my Provider, for myself, or the patient for whom I am responsible. I am aware that the practice of medicine is not an exact science and I do acknowledge that there have been no guarantees made to me as a result of treatment or performed examinations. I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement. I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Willow Medical, LLC.

_____ _____

Patient/Guardian Signature Date

OFFICE POLICIES & PROCEDURES FOR PATIENTS OF WILLOW MEDICAL, LLC (“WILLOW MEDICAL”)

OFFICE HOURS

Monday Closed
Tuesday-Thursday, 8:00 am-4:00 pm
Friday, 8:00 am-12:00 pm. (No Lab Draw on Fridays)

We may be reached at **539.208.5069** during office hours. If you need an appointment, refills, or test results, please call during regular office hours. Alternatively, you can communicate with our office by email at support@willowmedicalok.com
to contact you for scheduling appointments, medications, etc.

APPOINTMENTS

Willow Medical is committed to providing quality care to our patients. **Your first visit is considered an ESTABLISH AS A NEW PATIENT VISIT…NOT A WELLNESS VISIT.** Wellness visits are scheduled at another scheduled appointment time. To ensure timely continued care, we encourage patients to schedule follow-up

appointments in advance. When calling for an appointment, please provide your name, date of birth, telephone number, chief complaint/reason for visit, and any updates/changes in your insurance information, if applicable. While we strive to schedule appointments appropriately, **we do not offer urgent/emergency care**. We strive to give all of our patients same day appointments but this is not always possible. To ensure quality care, Willow Medical does not treat patients that we have not seen **(i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit).** Follow up visit may be required to be scheduled after testing has been completed, so that results may be reviewed by the practitioner and patient together, and an effective and appropriate plan for your healthcare can be determined.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please timely inform Willow Medical of your preferred pharmacy or changes to your pharmacy information. Call your pharmacy first for refill requests. Allow two to three business days for the completion of refills.

We also encourage our patients to review all their medications prior to their office appointments to request refills at that time, if needed.

ARRIVING FOR APPOINTMENTS

In order to ensure that we provide efficient and effective care for all of our patients, we appreciate it when patients arrive on time for their scheduled appointments and check in with our reception staff. Please bring the following with you to each and every appointment: your photo ID, insurance card, updated list of medications, test results (if applicable), and your co-pay. If you are a

new patient and have not completed your new patient paperwork, please arrive 30 minutes before your appointment to complete your paperwork. If you do not do so this could result in less time with the practitioner during your appointment, or having to schedule another appointment or to reschedule the appointment altogether.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of all of our patients, if you need to cancel a scheduled appointment please be courteous and call our office. We require at least 24-hour advance notice of cancellation for an upcoming appointment. If you fail to do so, **there will be a $75.00 cancellation fee added to your next appointment charges.****

Our practitioner's time is valuable and we routinely have individuals and patients who are waiting to be scheduled.

NO SHOW POLICY

A failure to show at the time of a scheduled appointment will be noted in your medical chart **"**as a **no-show"**

No-show appointments likewise inconvenience those individuals and patients who need access to timely medical care. If you fail to show for a scheduled appointment, **a no-show administrative fee of $75.00 will be added to your next appointment charges.****

****Please note that no-show/cancellation fee charges are solely the patient's responsibility and will not be billed to your insurance company.**

LATE SHOW POLICY

If you arrive 10 minutes or later than your scheduled appointment, then you will be asked to reschedule for the next available appointment.

INSURANCE

Willow Medical accepts most insurance plans. If you have specific questions regarding your insurance, please contact your Insurance Company to check to see if we are accepted by your provider. It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

PAYMENTS

Willow Medical currently accepts cash, personal checks, MasterCard, Discover and Visa.

Checks should be made out to Willow Medical, LLC (there will be a FEE of $45.00 (on return checks). It is the policy of Willow Medical to make all reasonable attempts to collect outstanding balances should they accrue. Patients **will not be scheduled in our office and will be directed to Urgent Care or elsewhere until outstanding balances are cleared.**

FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Willow Medical will be happy to complete forms and write medical letters as necessary. You will need an appointment to discuss the pending form that you will need. However, because this can be time consuming, please allow 7-10 days for completion of request forms/letters.

Note however,

Willow Medical does not do CDL/Department of Transportation Forms .

NARCOTICS AND ANTIBIOTICS POLICY

Willow Medical **will not fill antibiotics by phone without an appointment.**

Patients will be required to obtain narcotic medications for pain or other reasons through a pain management or other specialist and/or be encouraged, if appropriate, to consider alternative strategies for managing pain.

TERMINATION

Willow Medical, LLC (“Willow Medical”) acknowledges and respects a patient’s right to refuse medical treatment after receiving from the practitioner(s) reasonable information about the potential risks, benefits and/or estimated charges for such treatment. Similarly, the practitioner(s) with Willow Medical may terminate the patient-practitioner(s)
relationship if in the sole judgment of the practitioner(s) the patient:
(1) repeatedly fails to follow recommended treatment plans or consistently misses or cancels appointments;
(2) engages in rude, antagonistic, disruptive, violent or other inappropriate behavior towards the practitioner(s) or the Willow Medical staff or other patients;
(3) exhibits medication-seeking behavior;
(4) insists that the practitioner(s) provide services outside the scope of the practitioner(s) expertise;
(5) takes any action that disrupts or threatens to disrupt the practitioner-patient trust relationship; or
(6) has failed or is unable to pay for services after reasonable attempts to establish payment arrangements. Willow Medical will give notice of such termination to the patient as is reasonable or as otherwise required by
law to enable the patient the reasonable opportunity to find alternative medical care.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form of release of medical information must be completed and signed (which will be good for one year unless otherwise stated). All patients can request a copy of their medical records free of charge (one time) if they are to be emailed to you. If your request is for paper copies, a charge of $1.00 per page (you will be charged when picking up from our office). The law allows medical offices 30 days to complete requests for such records. However, our office puts forth every reasonable effort to respond to these requests in a timely manner.

By signing in the space below, I acknowledge and agree that I have read and that I understand the above Office Policies and Procedures of Willow Medical and agree to the same. I further acknowledge and agree that such Office Policies and Procedures may be updated, revised and/or superseded from time to time by Willow Medical in its discretion.

Print Name

Date

Signature

Authorization to Release Healthcare Information

Patient's Name:_____
DOB:_____
Previous Name:_____

I request and authorize_____
To release healthcare information of the patient named above to Willow Medical, LLC with the above address and phone number.

The request and authorization applies to:

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition or dates
- ☐ Other

Definition: Sexually Transmitted Disease (STD) as defined by Oklahoma law, **§63-1-517** includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid lymphogranuloma venerueum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), gonorrhea

◯ YES or NO ◯ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◯ YES or NO ◯ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

The authorization expires one year after it is signed.

_____ _____
Patient/Guardian Signature **Date**

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
Area Code & Telephone Number	State	Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow **Willow Medical** to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Willow Medical as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information (Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be Shared

1. Check one or more boxes below.

- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
- ☐ Mental Health Records
- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records

☐ Other_____

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐ 12 months from the date signed in Part V.B. ☐ Other (insert date or event): _____

B. Right to Revoke
I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. ☐ If checked and initialed, is authorized to share my protected health information for the purpose of marketing. I understand may receive either direct or indirect compensation for sharing my information in this case. Individual initials _____

3. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or noncommunicable disease.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative)	Date
Printed Patient or Legal Representative Name	Capacity of Legal Representative (if applicable)

Company Address:

The following information may only be completed by

☐ If checked by — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.