Patient Information Update

Acct # _____

Staff Review_____
Date_____

Pt Name:_____ DOB:_____
First Name MI Last Name

If Minor, Parent/Gaurdian Name:_____

Address: _____
Street City State Zip +

Home # (___)_____Cell # (___)_____Work # (___)_____Ext____

Email Address: _____ **Circle Preferred Communication: Home/Cell/Email**

Primary MD:_____ Ph #:_____
Name City/State

Primary Insurance Company: ☐ SAME AS PREVIOUS YEAR – If anything changed please complete

Policy ID#:_____ Policy Group #:_____
Policy Holder's Name:_____ DOB:_____/ ☐ Same as patient
Policy's Holder's relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Policy Holder's Address: _____ / ☐ Same as patient
_____
Phone#:_____ / ☐ Same as patient

Secondary Insurance Company: ☐ SAME AS PREVIOUS YEAR – If anything changed please complete

Policy ID#:_____ Policy Group #:_____
Policy Holder's Name:_____ DOB:_____/ ☐ Same as patient
Policy's Holder's relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Policy Holder's Address: _____ / ☐ Same as patient
_____
Phone#:_____ / ☐ Same as patient

Permission to Discuss Protected Health Information

I give Headache Wellness Center permission to discuss treatment and billing issues with the person(s) listed below. NO WRITTEN INFORMATION will be shared without an additional consent form.

Name	Relationship	Ph #

Phone and Email Communication-Please indicate your communication preferences.

Email: ☐ HWC **may** send me educational or practice information by email.
☐ **Do not** send detailed patient information in an email

Phone: **Please note: You WILL NOT receive appointment reminders if you select either of these options.**
☐ **Do not** leave detailed messages with other people that may answer the phone
☐ **Do not** leave detailed messages on voice mails

I have received a copy of Headache Wellness Center policies and HIPAA information.

_____ _____
Patient/Guardian/Responsible Party Signature Date

Headache Wellness Center Acct#:_____

_____

Date: _____

E-Prescribing Consent Form Staff Review: _____

E-Prescribing is a safe and effective way for your physician to send accurate, error-free prescriptions directly to the pharmacy of your choice.

Please list your preferred LOCAL pharmacy below:

_____

Pharmacy Name Location Phone Number

If your insurance company provides a Mail Order Pharmacy for you to use, please list below:

_____

Mail Order Pharmacy Location Phone Number

Electronic communication with your pharmacy is now becoming a standard of care for all patients and is an important element in improving the quality of patient care. The benefits of this program include:

Formulary and benefit transactions –Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification –Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

Understanding all of the above, I hereby provide informed consent to Headache Wellness Center to enroll me in the e-Prescribe program. All prescriptions are sent electronically directly to pharmacies.

By signing this consent form you are agreeing that Headache Wellness Center can request and use your prescription medication history from other healthcare providers and/or third- party pharmacy benefit payers' for treatment purposes.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Printed Patient DOB

_____ _____

Signature of Patient or Guardian Date