Core Wellness
33 Neill Ave
Helena, MT 59601
406-442-8508

Client Profile

DATE _____ / _____ / _____

Name _____ **DOB** _____ / _____ / _____

☐ **Male** ☐ **Female**

Address _____ **City** _____**State** ____ **Zip** _____

Phones*(check preferred)* ☐ **Home**_____-_____-_____ ☐ **Cell**_____-_____-_____ ☐ **Work**_____-_____-_____

Email _____

Emergency Contact _____ **Phone** _____-_____-_____ **Relation** _____

How did you hear about us?_____

GUARANTOR (if different from patient)

Name_____ **Relation to Patient**_____

Address_____

Phone_____

MEDICAL INFORMATION

What is your primary health concern? _____

What additional concerns would you like to address? _____

MEDICAL HISTORY

List all medications you are currently taking _____

List all herbs/vitamins/supplements you are currently taking _____

List all allergies *(food/environmental /drug)* ☐ None Known _____

SERVICES NOT BILLABLE TO INSURANCE

Some of the services offered at Natural Medicine Plus are not "accepted" as reimbursable therapies by insurance carriers. These treatments will not be covered by your insurance company and therefore you will be held responsible for full payment of these services. Some of these services include prolotherapy, trigger point injections, vitamin IV (intravenous) therapy, chelation therapy, HCG weight loss therapy and vitamin/ herbal/ homeopathic supplements.

I understand that I am financially responsible for the payment of these services if I agree to them as part of my treatment plan with my doctor.

X_____ _____
(Signature of Patient OR Parent of Minor) (Date)

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION
AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Core Wellness will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that nearly all treatment performed at Core Wellness is done in an open setting where incidental disclosures may occur. Private consultations are available on request. You also agree that Core Wellness may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activities or proceedings, leaving messages on answering machines or making phone calls to you regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

Please identify the family members, friends or other persons who are or will be involved in your care or payment for health care and with whom you authorize us to share your protected health information:

Name	Relationship to you	List information to be shared
_____	_____	_____
_____	_____	_____
_____	_____	_____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Core Wellness' NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Core Wellness has reserved the right to change the terms of its NOTICE OF PRIVACY PRACTICES, copies of the NOTICE, as amended, are available from Core Wellness at any of its offices or by sending a written request with return address to 33 Neill Avenue, Helena, MT 59601, Attn: Privacy Officer. You have the right to revoke this authorization, in writing, at any time, except to the extent that Core Wellness has taken action in reliance on it. A revocation is effective upon receipt by Core Wellness of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Core Wellness, or (d) two (2) years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:
PATIENT NAME: _____
PATIENT SIGNATURE: _____
Print Name _____ Date _____
Address: _____

OR
REPRESENTATIVE/GUARDIAN: _____
Print Name:_____ Date_____
Relationship to Patient: _____
Address: _____

Core Wellness

Financial and Clinic Policies

At Core Wellness (CW) we strive for the highest degree of customer satisfaction and to make your visits positive and caring. This requires not only exceptional clinical and administrative care, but also a clear understanding of our policies as it relates to you. Below you will find some important information. We ask that your read and acknowledge that you understand the policies by signing and dating at the bottom.

Financial Policy

- **In-network plans**: CW is an in-network provider with the following insurance plans: Blue Cross Blue Shield of Montana, Allegiance, Pacific Source, and Montana Health coop. However, even if you have a plan with one of these companies, each plan is different and outlines the requirements for coverage. We encourage all of our patients to know what their coverage is. CW does not know what your specific benefits are. This is up to you. For these plans, we will collect any co-payments or co-insurance at the time of visit. The remainder of your visit cost will be billed to your plan. If we find that your plan excludes any part of the service as determined by your benefits plan, we'll consider this service to be an excluded benefit in the future and will be billed appropriately. All patient responsible costs will be collected in full when due.
- **Out-of-Network plans**: CW is not in-network with all health plans, as well as some government plans such as Medicare, Medicaid, and Healthy Montana kids. Patients with an out of network plan will be required to pay all visit costs at the time of service. A courtesy claim will be sent to your insurance company and any money refunded will be paid directly to you.
- **Cash payments**: For patients without insurance or for procedures that are not billable to insurance, all payments will be collected at the time of service.
- **Payment Plans**: CW offers payment plans for financial hardship and for extensive service agreements. Please ask our staff for qualifications and specifics.
- **Delinquent Accounts**: in the rare and unfortunate circumstance that a patient account becomes delinquent, ALL fees assessed for the collection of debt will be the sole responsibility of the patient or their guarantor.

Cancellations and No-Shows: Our single greatest asset is the time we give patients. Therefore, we require a 24 hour notice for all cancelled appointments. Late Cancellations and No-shows will be assessed a fee equivalent to the fee for service for that appointment.

By signing below, you are acknowledging that you have read and understand the above policies.

_____ _____

Signature Date

_____

Print

Name: _____

Date:_____

We value our clients and want to do our best to keep you updated on current issues and promotions. We also want to hear from YOU! Please let us know if there are any topics you would be interested in Dr. Roush addressing to the public in a Q&A format.

_____

_____

EMAIL ADDRESS:_____
Please check one:

____ Yes, I WOULD like to receive emails regarding upcoming talks and promotions from CoreWellness.

___ No, I WOULD NOT like to receive emails regarding upcoming talks and promotions from CoreWellness.

Thank YOU from the COREWELLNESS team!