5319 Meadow Lane Court Suite 2 Sheffield Village Ohio, 44035 (440) 847-8973
Journey to Health and Wellness

Patient Registration Information

First Name:_____ M.I:__ Last Name:_____ Preferred Name:_____

Birth Date:_____ Age:___ Birth Sex: ☐Male ☐Female Gender Identity:_____

Preferred Pronouns: ☐He/Him ☐She/Her ☐They/Them Preferred Language:_____

Race:_____ Ethnicity:_____ Soc. Sec. #:_____

Street:_____ Apt/Ste:____ City:_____ State:___ Zip:_____

Home#:(___) _____ ☐ Preferred Cell#:(___) _____ ☐ Preferred

E-mail:_____ Can we sign you up for the patient portal ☐Yes ☐No

Previous Primary Dr:_____

Have you ever been a patient of Britney's? ☐Yes ☐No Within the last three years? ☐Yes ☐No

Referred By_____

Marital Status:_____ Spouse or Partners Name:_____

Employment Status: ☐Full Time ☐Part Time ☐Student ☐Unemployed ☐Disabled

Emergency Contact:_____ Phone:(___) _____ Relation:_____

Preferred Pharmacy _____ Location _____

Preferred Laboratory _____ Location _____ (we have an in house lab)

Preferred Imaging Center _____ Location _____

Office Visit Co-Pay
$_____
Employee Initials:_____

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Billing Information

Primary Insurance Company Information

Insurance Company: _____

ID#_____ Group#_____

Subscriber Information

First Name:_____ M.I:___ Last Name:_____ Relation to patient:_____

Date of Birth: _____ Address:_____

Apt/Ste:___ City:_____State:_____ Zip:_____

Secondary Insurance Company Information

Insurance Company: _____

ID#_____ Group#_____

Subscriber Information

First Name:_____ M.I:___ Last Name:_____ Relation to patient:_____

Date of Birth: _____ Address:_____

Apt/Ste:___ City:_____State:_____ Zip:_____

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ASSIGNMENT of BENEFITS / RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance company be made directly to Journey to Health & Wellness, LLC for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Journey to Health & Wellness, LLC to disclose any and all written information from the above-named insurance company and/or its designated representatives for reimbursement purposes for those services rendered.

I hereby release Journey to Health & Wellness, LLC, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company or designated representatives pertaining to its payment for services billed on my behalf.

By signing this Assignment and Release document I acknowledge the following:

- **I understand that this information will not be used unless the above-named insurance company or their designated representatives request records of information for reimbursement purposes; or seek to take action in reference to payment for services;**
- **I agree to participate and assist Journey to Health & Wellness, LLC and its designated representatives with any appeal process necessary to collect payment(s) for services rendered on my behalf;**
- **I have been advised of the provision of Federal and Ohio state Statutes, Rules and Regulations that protect the confidentiality of my medical/clinical records;**
- **I understand that this Assignment and Release document is an authorization and subject to revocation at any time, except that action has been taken in reliance thereof;**
- **I accept that his Assignment and Release document is valid while I am a patient at Journey to Health & Wellness, LLC and that it's my responsibility to keep the practice up-to-date with any insurance benefit changes;**
- **Journey to Health & Wellness, LLC is filing for insurance benefits to the above-named insurance company and it cannot assume responsibility for guaranteeing payment of any charges from the insurance company;**
- **Journey to Health & Wellness, LLC has the right to contract with a third-party to handle any billing and/or collection purposes;**
- **If an overpayment takes place, a refund check will be mailed to the authorized party that is due the overpayment;**
- **Journey to Health & Wellness, LLC shall be entitled to the full amount of its charges without offset**
- **I may request a copy of this signed Assignment and Release document**

_____ _____

Patient or Representative Signature **Date**

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Journey to Health and Wellness

Name_____

DOB _____

MRN _____

Please read and initial each item to acknowledge and authorize

I have read (or declined to read) and understand the HIPPA/Privacy Policy for Journey to Health and Wellness _____

I have read (or declined to read) and understand the Financial Policy for Journey to Health and Wellness _____

I authorize Journey to Health and Wellness to retain payment information knowing I will be notified prior to any transactions being processed _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider _____

I authorize Journey to Health and Wellness to release medical information required to process my claim _____

I authorize Journey to Health and Wellness to obtain/have access to my medication history _____

I authorize Journey to Health and Wellness to take photographs of exam findings to be uploaded into medical record _____

***This will remain affective for 1 year unless otherwise changed. ***

_____ _____

Patients Name Relationship to Patient

_____ _____

Signature of Patient/Legal Guardian Date

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Journey to Health and Wellness

FINANCIAL POLICY
JOURNEY TO HEALTH & WELLNESS, LLC

Thank you for choosing us as your health care provider!

The following is a statement of Financial Policy which we require you to read and sign prior to any treatment. Medical services require a commitment of time, energy and financial resources to accommodate your needs.

**** If you have health insurance, we will verify your benefits and eligibility.**

This verification is not a guarantee of payment and ultimately you are responsible for any changes or updates to the insurance plan.

Insurance Agreement:
Your insurance coverage is a contract between you and your insurance company. If we are a contracted provider with your managed care company, we will handle your claims according to our agreement with your particular company. As a courtesy to you, we are happy to file your primary and secondary insurance. If you have more than two insurance companies, you will be responsible for filing the third insurance.

Payment deductibles, co-payments and any non- covered services are due at the time of service. In the event deductibles and/or co-payments cannot be verified at the time of service, you will receive a mailed statement and are expected to render payment upon receipt. Non-insured patients are expected to pay in full at the time of service.

Minors:
The adult accompanying a minor is responsible for full payment or make arrangement for payment at the time of visit. A parent or legal guardian must accompany a minor for their initial visit.

Delinquent Accounts:
I agree to be financially responsible for any unpaid balance due to Journey to Health & Wellness, LLC for services and fees rendered. I understand that even though I have insurance, some services may not be covered under that insurance plan. If this occurs, I agree to pay the full amount due for services and fees.

*I grant permission to Journey to Health & Wellness, LLC, its agents or assignees, to discuss my account with and release any information to any

third-party payor via the U.S. Postal Service, fax, or any electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided.

*Also, it is understood and agreed that Journey to Health & Wellness, LLC reserves the right to assess a monthly finance charge, in accordance with Law, to any unpaid balance due. Further, it is agreed that should Journey to Health & Wellness, LLC determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery including any and all attorney's fees assessed by any court.

Appointments:

We see patients on an appointment basis. If you are a new patient, please arrive 30 minutes before your appointment time. If you are an established patient, please arrive 15 minutes before your appointment time. It is office policy that if a patient arrives late to their appointment that they may be required to reschedule depending upon the providers schedule for the day.

Cancellation Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed care. If an appointment is not canceled 24 hours in advance you may be charged a $50.00 fee this will not be covered by your insurance.

**Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have read/received (or declined to read/receive) a copy of the Notice of Privacy Practices/Patient Rights and Responsibilities of this office.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Would you like our correspondence with you marked "Confidential" ☐ Yes ☐ No

May we Identify ourselves over the phone ☐ Yes ☐ No

May we leave a detailed voicemail ☐ Yes ☐ No

Leave a message with call-back number only ☐ Yes ☐ No

May we send written information ☐ Yes ☐ No

I,_____, (the patient, or the guardian of the patient) hereby authorize Journey to Health and Wellness to release my medical information via postal mail, telephone, fax, or email to the following people.

Name:_____ **Relationship:**_____

Appointments ☐ Results ☐ Diagnosis/Treatment ☐ Billing ☐

Name:_____ **Relationship:**_____

Appointments ☐ Results ☐ Diagnosis/Treatment ☐ Billing ☐

Name:_____ **Relationship:**_____

Appointments ☐ Results ☐ Diagnosis/Treatment ☐ Billing ☐

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT

_____

Patient Name

_____

Relationship to Patient

_____

Signature Date

OFFICE USE ONLY

We tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgement

☐ A communication barrier prevented us from obtaining the acknowledgement

☐ The individual was unwilling to sign

☐ Other

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Name_____

DOB _____

MRN _____

COVID-19 Screening Questionnaire

Have you received a COVID-19 Vaccine Yes No Vaccine 1 Date: _____
Vaccine 2 Date: _____

A weak or compromised immune system (including but not limited to, conditions like diabetes asthma COPD cancer treatment radiation chemotherapy and any prior or current disease or Medical Condition), can put you at great risk for contracting COVID-19.

Please disclose to us any conditions that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us. It is also important that you disclose to this office any indication of having been exposed to COVID-19 or whether you have experienced any signs or symptoms associated with the COVID-19 Virus.

Do you have a fever or above normal temperature?	Yes	No
Have you experienced shortness of breath or had trouble breathing?	Yes	No
Do you have a cough?	Yes	No
Do you have runny nose?	Yes	No
Have your recently lost or had a reduction in your sense of smell or taste?	Yes	No
Do you have a sore throat?	Yes	No
Have you traveled outside of the United States by air or cruise ship int he past 14 days?	Yes	No
Have you traveled within the United States by air, bus, or train within the past 14 days?	Yes	No
have you been in contact with someone who tested positive for COVID-19 in the last 14 days?	Yes	No
Have you been in cantact with someone suspected of having COVID-19 in the 14 days?	Yes	No

If so have you been tested for COVID-19 Yes No

☐ Positive ☐ Negative ☐ Awaiting Results

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature of patient/Legal Guardian Date

B. Algood CNP _____

Prescreened By Date

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Journey to Health and Wellness

Name_____

DOB _____

MRN _____

COVID-19 PANDEMIC TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other clinic patients, the characteristics of the virus, and the characteristics of office procedures, there is an elevated risk of you contracting the virus simply by being in a medical office.

To provide a safe environment for our patients and staff, Journey to Health & Wellness, LLC follows the applicable Ohio and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgment

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

X _____ X _____

Signature of patient/Legal Guardian Date

X B.Algood CNP

Britney Algood CNP

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Journey to Health and Wellness

Name_____

DOB _____

MRN _____

Health History Intake Form

Other providers involved in your care

Doctor	What do you see them for

Allergies

Medication/Food	Reaction	Severity

Medications (including vitamins/herbs/over the counter)

Name of Medication	Dosage	Directions	Reason for Medication

Screening

Screening	Year	Normal	
Last Mammogram			
Last Dexa Scan			
Colon Cancer Screening			
Diabetic Foot Exam			
Diabetic Eye Exam			
Urine Microalbumin			

Feelings of helplessness or hopelessness □ Yes □ No
Little or no interest or pleasure in doing things □ Yes □ No
Have you fallen in the last year □ Yes □ No

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Name_____

DOB _____

MRN _____

Have you	No	Yes	Last	Outcome
Pneumonia Vaccine				
Flu Vaccine				
COVID Vaccine				

Habits

Alcohol: ☐ None ☐ Yes: How many drinks/day _____frequency/week _____
What kind _____

Tobacco: ☐ None ☐ Former—How many years did you smoke for _____ # packs per day _____
Current Smoker-- ☐ Yes: #packs per day____ Start Date_____
Interested in quitting ☐ No ☐ Yes
Have you ever used smokeless tobacco (chew) ☐ No ☐ Former ☐ Yes—Frequency _____
Have you ever used electronic smoking devices ☐ No ☐ Former ☐ Yes—Frequency _____

Other Recreational Drugs: ☐ No ☐ Former -- What kind_____
How long _____ How much _____Date of sobriety _____
Successful Treatment _____
☐ Current Use—Name _____Frequency _____How much_____
Previous treatment _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student
Current Occupation:_____Who do you live with:_____
Do you have a good support system: ☐ No ☐ Yes
Hobbies:_____
Pets:_____
Other:_____

Family History

Any new information since last appointment

Who	Dec	Alive	Age	History
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling				
Sibling				

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Name_____

DOB _____

MRN _____

Past Medical History

Any new information since last appointment

Diagnosis	Yes	No	Year Presented	Type/Notes
Headaches				
Migraines				
Stroke				
Dizziness				
Seizures				
Hearing Loss				
Diabetes				
Thyroid Disease				
High BP				
Low BP				
Blood Clots				
Heart Disease				
Irregular Heart Rhythm				
High cholesterol				
Heart Attack				
Heart Failure				
Obesity				
Glaucoma				
Macular Degeneration				
Pneumonia				
Heart Burn				
Stomach Ulcers				
GI bleed				
Liver Disease				
Kidney Disease				
HIV/Aids				
Hepatitis				
Breast Disease				
Prostate Disease				
Frequent UTI's				
Asthma				
COPD				
Depression				
Anxiety				
ADHD/ADD				
Bipolar				
Chronic Fatigue				
Fibromyalgia				
Arthritis				
Osteoporosis				
Gout				
Chronic Wounds				
Cancer				

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Name_____

DOB _____

MRN _____

Past Surgical History

Any new information since last appointment

Surgery	Year	Complications/Notes

Females Only

Age of first period:_____ **How often do you have a period:**_____ **How many days does it last:**_____

First day of last period:_____ **Menstrual Flow:** □ Heavy □ Medium □ Light **Spotting between cycles** □ Yes □ No

Pain during cycle: □ Intolerable □ Tolerable **Any chance of Pregnancy:** □ Yes □ No

Current Birth Control:_____ **Last pap smear:**_____ **Results:**_____

Menopausal □ No □ Yes □ Post **Age:**____ Hysterectomy:□ No □ Full □ Partial Do you have any symptoms:

□ Yes □ No **Hot Flashes** □ Yes □ No **Hot Flashes** □ Yes □ No **Bleeding** □ Yes □ No
□ Yes □ No **Increased hair loss** □ Yes □ **No Increased Anxiety** □ Yes □ No **Pain during sex** □ Yes □ No
□ Yes □ No **Unusual vaginal discharge**

Total Pregnancies:___ **Total live births:**___ **Total Vaginal Births:**___ **Total miscarriages:**___**Total abortions:**____
Total C-sections:____

Ever Sexually Active □ Yes □ No **Age of first sexual encounter:** ___ **Number of Sexual Partners:**_____

Sexual Preference □ Male □ Female □ Both □ Other _____

Do you use condoms every time □ Yes □ No **Ever diagnosed with a sexually Transmitted Infection** □ Yes □ No

What type:_____ **When:**_____ **Cured:** □ Yes □ No

MALE

Ever Sexually Active: □ Yes □ No **Age of first sexual encounter:**___ **Number of Partners Sexual:** ____

Preference: □ Male □ Female □ Both □ Other _____ **Do you use condoms every time:** □ Yes □ No

Penile Discharge: □ Yes □ No **Testicular Pain:** □ Yes □ No **Testicular Swelling:** □ Yes □ No

Pain with ejaculation: □ Yes □ No **Erectile dysfunction:** □ Yes □ No **Urinary Hesitancy:** □ Yes □ No

Post Urine Dripping □ Yes □ No **Slow Flow** □ Yes □ No **Enlarged Prostate** □ Yes □ No

Low Testosterone □ Yes □ No **Ever diagnosed with a sexually Transmitted Infection** □ Yes □ No

What type:_____ **When:**_____ **Cured:** □ Yes □ No

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Journey to Health and Wellness

Authorization to Release or Obtain Protected Health Information ***PLEASE PRINT***	MRN#
Patient Name: (Last)	(First)
Phone:	Maiden/Other Name:
Date of Birth:	Social Sec. No.
Address:	
City:	State: Zip:

I authorize Journey to Health & Wellness, LLC to release information contained in my medical/clinical record to the following person or organization indicated below:	**INFORMATION TO BE RELEASED** Check or Circle Please indicate date(s) or date range, if known
Institution or Requestor:	E&M / Office Notes/Consult Notes ☐
Attention to:	Radiology Reports ☐
Address:	Labortory Test Results ☐
City State Zip	Other Lab Results ☐
Phone	Treatment plans ☐
I authorize the following institution to release protected health information contained in my medical record to Journey to Health & Wellness, LLC:	Immunization Record ☐
	Discharge Summary ☐
	2 Year Summary of all records ☐
Institution or Requestor:	Other: ☐
Phone:	Comments:

REASON FOR DISCLOSURE Check or Circle		**Please Check if you want Information Protected by CFR 42 Released:**	
Continuation of Care ☐	Medical Consultation ☐	Drug Abuse ☐	Psychotherapy Notes ☐
Legal Representative ☐	Transfer to New PCP	Alcohol Abuse ☐	STD Test Results ☐
Social Security Disability ☐	Claim# _____	HIV/AIDS ☐	
Worker's Comp ☐	Insurance Claim#_____	Anticipated Completion Date: (Please Circle One) 30 Days	
Other: _____		60 Days	
		90 Days	

This authorization to disclose information may be revoked by the patient at any time except to the extent that action has been taken in reliance thereon by sending a written revocation to the Compliance Officer JOURNEY TO HEALTH & WELLNESS, LLC 5319 Meadow Lane Court Sheffield Village, OH 44035 This authorization expires 60 days from the date of signature.

Signature of Patient Date:

Other Legal Signature Date:

FOR JOURNEY TO HEALTH & WELLNESS, LLC USE ONLY BELOW

Approved ☐ **Denied** ☐ Completion Date _____

Reason: _____

Employee Signature:

IDENTIFICATION VERIFIED
Driver's License ☑
Other Photo ID ☐

WT
Employee (Printed Name)