Demographic Information

Legal Name_____

Preferred Name_____ Date of Birth_____

Address_____

City/State/Zip_____

Home Phone:_____Cell Phone: _____

Email Address_____@_____._____

Cell Phone Carrier (needed for text messaging)_____ SS#_____
(required for insurance billing)

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone Call ☐ Text ☐ E-mail (check all that apply)

Circle One: Gender Assigned at Birth: ☐Male ☐Female Gender Identity: ☐ Male ☐ Female ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Other (check one)

EMPLOYMENT

Employment Status: ☐ Employed FT ☐ Employed PT ☐ Retired ☐ Unemployed ☐ Disabled ☐ US Military

If employed: Employer_____Occupation_____

Business Address_____

City/State/Zip_____

Business Phone_____ May We Contact You at Work ☐ Yes ☐ No

INSURANCE ☐ **No Insurance Coverage** (give pt info on DPC plan)

Health Insurance Coverage: _____

ID#_____ Group #_____

Effective Date_____ Insurance Subscriber: ☐ Self ☐ Spouse/Parent ☐ Other_____

PREFERRED LOCAL PHARMACY _____

MAIL ORDER PHARMACY_____

OTHER PHARMACY_____

EMERGENCY CONTACT(Please indicate which of your contacts is your next of kin – check the box ☐)

☐ Name _____Phone_____

☐ Name_____Phone_____

MEDICAL HISTORY

Name_____ DOB_____

Your Past Medical History and Chronic Medical Conditions (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer's/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Chronic Fatigue Syndrome	
Fibromyalgia		Other:		Other:	
Other:		Other:		Other:	

Past Surgical History (please indicate year if known)

Tonsillectomy		Adenoidectomy		Gall Bladder Removal	
Thyroid Removed		Heart Bypass		Heart Valve Replacement	
Bowel Surgery		Hysterectomy		Tubal Ligation	
Vasectomy		Wisdom Teeth Removal		Hip Replacement R L	
Cataract Removal		Knee Replacement R L		Spleen Removed	
Face Lift		Tummy Tuck		Eye Lift	
Ear Tubes (Myringotomy)		Carotid Endarterectomy		Hammer Toes	
Foot Surgery		Elbow Surgery		Hand Surgery	
Colonoscopy		EGD Endoscopy		Heart Catheterization	
Knee Laparoscopy		Abdominal Laparoscopy		Bronchoscopy	
Other:		Other:		Other:	
Other:		Other:		Other:	

Reviewed by _____ Date_____

Name_____DOB_____

Family History (please indicate the diseases your relatives have (check all that apply)

High Blood Pressure		High Cholesterol/Triglycerides		Diabetes Type 1	
Diabetes Type 2		Low Thyroid (hypothyroid)		Overactive Thyroid (hyperthyroid)	
Anxiety		Depression		Bi-Polar Disorder	
ADHD/ADD		Schizophrenia		Migraine Headaches	
Tension Headaches		Low Back Pain		Upper Back Pain	
Neck Pain		Hearing Loss/Hard of Hearing		Glaucoma	
Cataracts		Wears Glasses		Wears Dentures	
Eczema		Psoriasis		Breast Cancer	
Colon Cancer		Lung Cancer		Thyroid Cancer	
Skin Cancer		Brain Tumor		Bladder Cancer	
Brain Aneurysm		Abdominal Aneurysm		Arthritis	
Epilepsy		GERD/Heartburn/Reflux		Atrial Fibrillation (A-fib)	
Heart Attack		Congestive Heart Failure (CHF)		Alzheimer's/Dementia	
Ankle Swelling (Edema)		Varicose Veins		Stroke (CVA)	
Diarrhea		Constipation		Prostate Disease	
Low Blood Pressure		Urine Leakage (Incontinence)		Hemorrhoids	
Liver Disease		Kidney Disease		Erectile Dysfunction	
PMS		Heavy Periods		PCOS	
Seasonal Allergies		TMJ (jaw problems)		HIV/AIDS	
Overweight/Obesity		Fibrocystic Breast Disease		Other:	
Other:		Other:		Other:	

Your Medications

Medication Name	Dose	Morning Pill	Lunch Pill	Dinner Pill	Bedtime Pill	Just As Needed

Reviewed by _____Date_____

Name_____DOB_____

Your Medicine Allergies (check all that apply and indicate reaction)

Medication Name	X	Reaction
Penicillin/Amoxicillin		
Sulfa/Sulfur/Bactrim		
Zithromax/Azythromycin		
Erythromycin		
Clindamycin		
ACE Inhibitors (Lisinopril/Prinivil etc.)		
Statins (Cholesterol medicine)		
Codeine		
Oxycodone/Hydrocodone (Vicodin/Norco/Percocet)		
Morphine		
Sudafed (Pseudoephedrine)		
Other:		
Other:		
Other:		

Your Food Allergies:

Food	X	Reaction
Strawberries		
Milk/Dairy		
Wheat/Gluten		
Peanuts/Peanut Butter		
Other Nuts		
Shrimp/Shellfish		
Fish		
Eggs		
Soy		
Chocolate		
Other:		
Other:		

Environmental Allergies:

Allergen	X	Reaction
Dogs		
Cats		
Pollen		
Dust		
Grass		
Mold		
Other:		
Other:		

Reviewed by_____Date_____

Name_____DOB_____

May we share any vaccine information with the state/national immunization registry? ☐ Yes ☐ No

Do you have a living will or advanced directives (what you want done if you can't make medical decisions for yourself?

☐ Yes (please provide us with a copy)

☐ No Would you like information about this ☐ Yes ☐ No

Do you have a healthcare proxy (someone to make medical decisions for you if you are unable to do so?

☐ Yes (please provide us with a copy) Name_____

☐ No Would you like information about this ☐ Yes ☐ No

Do you struggle to pay your bills? ☐ Yes ☐ No

Do you have food insecurity (trouble getting enough to eat for you and your family)? ☐ Yes ☐ No

Do you have transportation insecurity (trouble getting rides to where you need to go)? ☐ Yes ☐ No

Is your housing stable (are you at risk of being homeless)? ☐ Yes ☐ No

Is your home safe (enough heat, running water, proper lights, no broken steps or railings etc.) ☐ Yes ☐ No

Are you at risk for domestic abuse/violence? ☐ Yes ☐ No If yes, Would you like help? ☐ Yes ☐ No

Are there any other issues you would like to discuss with us? ☐ Yes ☐ No If yes, what?_____

_____

_____

We are required by the federal government to collect certain non-medical information. Please be aware that this information is optional for you to provide. This information may help us care for you better. When our practice provides this information to agencies requesting it, the format does not provide your name or personally identifiable information.

Race: ☐ American Indian or Alaskian Native ☐ Black or African American ☐ Asian ☐ Pacific Islander/Hawaiian ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Heterosexual/Straight ☐ Bisexual ☐ Other ☐ Decline to Disclose

Gender Identity: ☐ Female ☐ Male ☐ Transgender-Female to Male ☐ Transgender-Male to Female ☐ Gender Queer

☐ Gender Fluid ☐ Other ☐ Decline to Disclose

Reviewed by_____Date_____

Peaceful Balance Health & Wellness Services, LLC
Lorraine W. Bock, DNP, FNP-C, ENP-C, FAANP
9 East High Street – Rear
Carlisle PA 17013
717-440-0098 – phone
717-918-5784 – fax
www.peacefulbalancehealthcare.com

Consent to Treat

I _____ give permission for Peaceful Balance Health and Wellness Services to give me medical treatment.

I allow Peaceful Balance Health and Wellness Services to file for insurance benefits to pay for the care I receive **if** I am not enrolled in a subscription program.

I understand that:

- I allow Peaceful Balance Health and Wellness Services to send my medical record information to my insurance company, **if** necessary.
- I understand that I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay **if** I am using insurance to cover my medical care.

I understand :

- I have the right to refuse any procedure or treatment
- I have the right to discuss all treatment with my clinician

_____ _____
Patient Signature Date

_____ _____
Patient or Guardian Signature Date

_____ _____
Printed Signature

cc: patient file

Name_____DOB_____

CONSENT TO USE NON-SECURE TEXTING AND/OR EMAIL FOR COMMUNICATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").1 The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" (PHI) by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. BrightStar Health and Wellness Services, and Peaceful Balance Health and Wellness Services "The Practice" are covered entities under the act. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

Standard text messaging and e-mail is not considered HIPAA compliant and may be subject to unintended loss of PHI through hacking or other failure. Whereas, "The Practice" is subject to the provisions of HIPAA and is responsible for protecting the PHI contained in my records and in all communications with me about my health, for ease of communication,

I give consent for "The Practice" to communicate with me via (check all that apply)

☐ Standard Text Messaging *please provide phone number for texts*_____

☐ Standard E-mail *please provide email address*_____

I understand that by signing this document I am releasing "The Practice" from liability regarding the loss of my PHI through communication via text or email to the number or email address listed above.

I understand that I can access my PHI and communicate with my providers at "The Practice" through a secure portal provided by ASP.MD the electronic health record used by "The Practice."

"The Practice" will take every precaution to assure that communication sent to the above designated number or email is directed appropriately but under no circumstances takes responsibility for any unintentional errors of loss of PHI that might occur during communication.

Patient Signature_____Date_____

Signature of Representative of "The Practice"_____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. _____Initials

Name_____DOB_____

PRIVACY NOTICES

NOTICE OF PRIVACY PRACTICES: This notice provides information on how BrightStar Health and Wellness in MA and Peaceful Balance Health and Wellness in PA ("The Practice") will use and disclose your Protected Health Information (PHI). This notice also explains important rights you have regarding your PHI. "The Practice" reserves the right to change this Privacy Notice at any time.

USE AND DISCLOSURE OF INFORMATION: We will use and disclose your PHI for a variety of treatment, payment, and healthcare operations purposes. Such disclosure of your PHI may be made via mail, telephone, facsimile (fax), modem, email, and/or internet as may be necessary for "The Practice" to conduct business for these purposes. If your PHI contains any privileged or additionally protected information under State of Federal Law (such as HIV testing/status, mental health records, or sexually transmitted infection (STI) etc.) you will be asked to sign a specific authorization for the release of this additionally protected information. All PHI at "The Practices" will be handled in accordance with the Health Information Portability and Accountability Act of 1996.

Specifics of the HIPAA of 1996 can be found on the CDC website at https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge.

RELEASE OF INFORMATION TO SPECIFIED PARTIES: I understand that I have can consent to the release of my PHI to specified parties. I have indicated below my preference in the release of my PHI to specified parties.

☐ I DO NOT give permission to "The Practice" to release my medical information to anyone – with the exception of the release of my PHI in order to facilitate emergency or urgent medical care and restrict the release of that information to that which is necessary for the treatment of said emergency.

☐ I give permission to "The Practice" to speak with and release to my PHI to the following individuals:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

RESTRICTIONS ON USE AND DISCLOSURES: You have the right to request how "The Practice" uses and discloses your health information for the purposes of treatment, payment, and healthcare operations and disclosures to family and friends. You also have the right to ask us to send communications including your PHI to an address, phone number (text), or e-mail of your choice. You also have the right to advise us on how to leave communications (ie. messages on a voicemail or answering machine, with a person who answers the phone). These instruction should be outlined on the communications document included in this packet.

Signature_____ Date_____

Practice Representative_____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. I understand that if I revoke this consent "The Practice" may refuse to provide me with treatment. I also understand that this consent authorizes "The Practice" to use and disclose all past information documented in my medical record in accordance with the Privacy Notices provided. _____Initials

Peaceful Balance Health & Wellness Services, LLC
A Direct Primary Care Practice

AUTHORIZATION TO *OBTAIN* HEALTH INFORMATION

1. _____ _____
Name of **Patient Birth Date**

_____ _____
Street **Address** **City, State, Zip**

2. **AUTHORIZES:**

Peaceful Balance Health & Wellness Services, LLC

_____
Name of Health Care Provider/Plan/Other
9 East High Street - Rear

_____
Street Address
Carlisle PA 17015

_____
City, State, Zip Code

3. ***TO OBTAIN*** **PROTECTED HEALTH INFORMATION FROM:**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

4. **INFORMATION TO BE OBTAINED:**

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ X-Ray Reports
- ☐ Consultations
- ☐ Physician Progress Notes
- ☐ List of Allergies
- ☐ Physician Orderrs
- ☐ Entire Record
- ☐ Lab Results
- ☐ Medication Lists
- ☐ Problem List
- ☐ Immunization Records
- ☐ Other: _____

For the following dates: _____
_____

In compliance with the Pennsylvania Mental Health Procedures Act:
___ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.

___ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

_____

5. **PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)**

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Personal
___ Changing Physicians
___ Other (Specify): _____

6. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

7. **Your Rights with Respect to This Authorization:**

- **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.

- **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of Health Information Management at (610) 776-3513. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following date(_____s) _____ or_____ _____ event(s) (specify event) _____. If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

9. **Signature of Patient:** _____ **Date:** _____
(If signed by person other than patient, state relationship and authority to do so.)

Patient is: ___ Minor ___ Incompetent ___ Disabled ___ Deceased

Legal Authority: ___ Custodial Parent ___Legal Guardian ___ Executor of Estate of Deceased
___ Power of Attorney for Healthcare ___ Authorized Legal Representative

Signature of Witness: _____ **Date:** _____