Trail Creek

WELLNESS

CONSENT FORMS

Trail Creek
WELLNESS

Demographics

Patient Name (Print) _____

Preferred Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Gender _____ SSN # _____

Preferred Language _____ Marital Status _____

Emergency Contact _____

Relationship _____ Cell Phone # _____ Gender _____

Race:

_____ American Indian

_____ Asian

_____ African American

_____ White/Caucasian

_____ Other

Ethnicity:

_____ Hispanic/Latino

_____ Non-Hispanic/Latino

Primary Insurance _____

Secondary Insurance _____

Responsible Party (IF UNDER 18) _____

Employer _____ Employment Phone # _____

Primary Care Provider _____

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

Integris and Me Application

Integris and Me is a patient portal that brings you a secure, powerful suite of new online tools, including the ability to send messages to your provider's office, request appointments online, and so much more. Due to our high call volume, this may be an easier way for you to contact our office.

Integris and Me allows a patient to →

- Communicate with your provider and get answers to your medical questions from the comfort of your home.
- Request a refill for any of your refillable medications.
- Access your test results and your provider's comments within a week.
- Schedule your next appointment or view details of your past and future appointments.

We are NOT set up to pay a bill online. Please call our office during business hours to pay a bill or pay on your account.

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

Copayment Policy

- ALL patients must pay their copayments before being seen by the provider.
- Copayments cannot be billed after you have completed the visit.
- If unable to pay the copay at the time of service, you will kindly be asked to reschedule your appointment when you are able to make the copayment.

Prior Balance Policy

- Prior balances must NOT exceed $200.00, in order to see the provider.
- When scheduling an office visit or a telemedicine visit, you are expected to pay your copayment (if you have insurance) or pay the self-pay cost, AND towards your prior balance. You must pay the required minimum if you have a prior balance on your account.
- If you arrive to your appointment with a large prior balance, you will be asked to set up a payment plan, pay towards the first payment, in addition to your copay, BEFORE being seen by the provider.

No-Show Policy

- **No-Show fee is $75.00!!!!**
- If you are unable to make it to your scheduled appointment, please call our office BEFORE the appointment time to cancel or reschedule.
- Please DO NOT email, text, or contact the after-hours phone to cancel, call our office during business hours.

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

HIPAA Consent Form

- HIPPA - Health Insurance Portability and Accountability Act
- I _____, understand that as part of my medical care, this office originates and maintains records describing my health history, symptoms, examinations, test results, treatments, and any plans for future care or treatment. I further understand this information serves as a basis for planning my care and treatment, a means for communication among health professionals who contribute to my care, a source of information for applying my diagnoses and treatment information to my bill, a means for third-party payer to verify that services were billed as actually provided, and a tool for routine healthcare operations such as assessing quality and revieing the competence of healthcare professionals.
- *By Oklahoma Law, we are required to notify you that the information authorizes for release may include records which may indicate the presence of communication or venereal diseases which may include, but are known as Acquired Deficiency Syndrome (AIDs).*

Other than myself, this office has permission to use and disclose information regarding my medical care to the following specific person(s). Please list below.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

Consent for Treatment and Understanding

- I _____, authorize Trail Creek Wellness, and any employee working under the direction of the provider, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical of items, or items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals.
- I _____, authorize this practice to furnish information to the identified insurance carrier(s) for all payment activities. I consent to assign all payments for services directly to this practice. I further my consent to the use of any practice operational needs as identified in the Practice Privacy Policy.

I have read and understand the consent policy stated above and agree to accept full responsibility as described above.

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

Text Messaging Policy

SMS Messaging and iMessage are NOT encrypted. If you send a text to a provider, you are consenting to the unprotected transfer of patient health information. If you understand, place your initials by each statement.

- _____ I understand that the information between myself and my health provider, by SMS or iMessage, is subject to unencrypted communication. This means your information is not protected and may be unauthorized access. This also includes shared photos and videos.
- _____ I understand that I may only receive text messaged responses from my provider at a reasonable hour
- _____ I understand that text messaging may not be the fastest way to get ahold of the provider. Calling our office during business hours is preferred.
- _____ I understand that there may be a fee for texting any provider.

Date _____

Patient Name _____

Patient Signature _____

Trail Creek
WELLNESS

COLLECTIONS PATIENT AGREEMENT

I, _____, (Patient Name) understand that if my balance with Trail Creek Wellness goes to collections, I am subject to paying an additional 23% of my total balance in collections to the CAC Collections Company. I understand that this fee is required and is non-refundable.

I have read and agree to the above information.

Patient Name: _____

DOB:_____

Patient Signature:_____

Date:_____

Legal Guardian Signature:_____

Date:_____