Healwell Primary Care
Compassion Meets Care

Hello,

Welcome to Healwell Primary Care. Please fill out these forms to the best of your ability and help us with providing you with comprehensive care. We appreciate your patience and thank you for allowing us to participate in your care.

Sincerely,

Healwell Staff

***** NAME AND DATE ON EVERY PAGE PLEASE *****

Allergy Questionnaire-Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)

☐ Cough	☐ Cold	☐ Congestion
☐ Difficulty breathing	☐ Headaches	☐ Wheezing
☐ Runny nose	☐ Sore throat	☐ Itchy/irritated eyes
☐ Sinus pain	☐ Ear pain	☐ Unexplained fatigue
☐ Skin irritation	☐ Snoring	

2. Have you ever been diagnosed with asthma or bronchitis? ☐ Yes ☐ No

3. Do you experience symptoms of allergies? ☐ Yes ☐ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)

☐ Bloating after eating	☐ Diarrhea	☐ Cough
☐ Constipation	☐ Upset stomach	☐ Wheezing
☐ Stomach pain	☐ Indigestion	☐ Nausea
☐ Vomiting	☐ Tingling of the mouth or any other unusual sensation	

Healwell Primary Care
(312) 971-7147
www.healwellprimarycare.com

Patient Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due At The Time Of Service Unless Prior Arrangements Are Made. We Accept Cash, Visa, Master Card.

Insurance Participation

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of your insurance Cards. Blood lab fee will be charged to your insurance company but in the event of non coverage test, you will be responsible to pay for tests. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

Please note again that balance is your responsibility. We will mail 3 statements on a monthly basis. If the balance due is not paid in full after 3 statements, the patient consents to charging their credit card on the file. Patient may clarify any billing questions by calling us or sending us a email at office@healwellprimarycare.com

Patient consents to Email, text and voice reminders and messaging. Patient gives consent to retrieve prescription history when the request is triggered.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. Unless cancelled, at least 24 hours in advance, our policy is to charge $50.00 fee for appointments not canceled 24 hours in advance. You can Call us/Leave a voicemail or Email us at office@healwellprimarycare.com to cancel your appointment in advance. NO SHOW FEE is non refundable and will be charged automatically on the day of NO SHOW using the Credit card that is given on file.

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

Name: _____ Date: _____

Signature: _____

Healwell Primary Care
(312) 971-7147
www.healwellprimarycare.com

CONSENT FOR TREATMENT

General Consent to Treat

I voluntarily consent to treatment and/or related services by Healwell Primary Care which may be advised and recommended by the attending physician. I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for Healwell Primary care to render such emergency treatment and/or transfer myself or my child to a hospital for treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this organization.

I am aware that I may stop my treatment with Healwell Primary care at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Healwell Primary care may stop treatment.

I acknowledge that I have received a copy of Healwell Primary care Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by Healwell Primary care and states my rights with respect to my Protected Health Information (PHI). I understand that Healwell Primary care has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Healwell Primary care changes this Notice, a revised Notice will be posted in the office waiting area and that I may obtain a current Notice of Privacy Practices at any time from the front desk.

Name: _____ Date: _____

Signature: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

ABI (93922)

NAME: _____
DOB: _____/_____/_____

AGE > 50 OR WITH HISTORY OF HTN/ HLD/ T2DM, SMOKING PV EVAL DONE.

ANKLE **BRACHEL**

RIGHT

LEFT

_____ _____

PROVIDER SIGNATURE ***DATE***

Name: _____

Dob: ___/_____/_____

Today's Date: __/_____/_____

Healwell Primary Care

Health Questionnaire

PATIENTS>50

1. Do you get short of breath at rest or while exerting yourself? __YES __NO
2. Have you experienced chest pain/ tightness/ pressure recently? __YES __NO
3. Have you ever had an abnormal EKG? __YES __NO
4. Do you have high blood pressure? __YES __NO
5. Do you currently smoke or have a history of smoking? __YES __NO
6. Have you had any fainting spells or loss of balance? __YES __NO
7. Do you have high cholesterol? __YES __NO
8. Do you ever have numbness or pain in your legs? __YES __NO
9. Have you been diagnosed with diabetes? __YES __NO

FOR OFFICE USE ONLY

PATIENT MAY QUALIFY FOR FOLLOWING TESTS FOR ANSWERS CIRCLED YES ABOVE

	#1-4	ECHOCARDIOGRAM
	#5 AND IF 65 Y/O MALE	AAA SCREENING
	#6	CAROTID DOPPLER
	#7	LIMITED CAROTID W/ IMT (intima media thickness)

Tests Ordered:

	ECHOCARDIOGRAM
	AAA SCREENING
	CAROTID DOPPLER
	LIMITED CAROTID W/ IMT (intima media thickness)

Scheduled:_____/_____/_____.

Time:_____:_____.

_____

Provider Signature

IMAGING

Name: _____ DOB: _____

Cost for Ultrasound it: _____

Date of your Appointment: _____

Reason for exam: to look for any abnormalities with your heart or blockage in arteries of neck that take blood to the brain.

What to expect on Echo/Carotid Ultrasound:

Please make sure to wear a comfortable t-shirt on the day of your appointment. There is no need to Fast or hold any of your medications for this exam. You will arrive at the main lobby and check in as your routine appointment. Staff will take you to the Ultrasound waiting room for your testing.

Please make sure to cancel your appointment at least 48 hours in advance if your unable to make it. You can call us or email us at office@healwellprimarycare.com to cancel your appointment. Availability for Ultrasound tech is extremely limited so we will enforce NO SHOW FEE of $50.00 if you do not cancel your appointment.

Thank you.

Signature:_____