Access Wellness Group, Inc
2401 Regency Road Suite 101
Lexington, KY 40503

Patient Demographic Information

Patient Information:

Last Name: _____ First Name: _____ MI _____

DOB: _____ Gender: M F SSN: ____-___-____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: ( )_____ May we contact you there? □ Yes □ No

Work Phone: ( ) _____ May we contact you there? □ Yes □ No

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: ( ) _____

Primary Care Physician – Name: _____

Address: _____

Phone: ( ) _____

Parent or Legal Guardian Information (if patient is under 16 years of age):

Relationship to Client: _____

Last Name: _____ First Name: _____ MI _____

DOB: _____ Gender: M F SSN: ____-___-____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: ( )_____ May we contact you there? □ Yes □ No

Work Phone: ( ) _____ May we contact you there? □ Yes □ No

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: ( ) _____

How did you hear about *Access Wellness Group*?

___ Insurance ____ Physician ____ Employer ____ Friend

___ Website ____ Newspaper ____ Other: _____

In the future, can we mail a patient satisfaction survey to your home? □ Yes □ No

May we leave a reminder message at your home? □ Yes □ No

Date completed: _____

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Patient Rights and Responsibilities and Patient Consent for Treatment

Each of our patients has the right to:

1. Receive services in a timely manner.
2. A comprehensive discussion of treatment options for your condition.
3. Participate with your provider in making decisions regarding your care.
4. Express complaints about AWG by contacting the Director of Clinical Services.
5. Have your confidentiality maintained in keeping with all applicable Federal and state regulations, including HIPAA. (Refer to your copy of AWG's HIPAA Privacy Notice.)
6. Be treated with respect without regard to race, sexual orientation, religion or nationality.
7. Know that your provider is required by law to report any incidents of domestic violence or child/spouse/elder physical or sexual abuse to the appropriate governmental agency without exception.

Patient responsibilities are to:

1. Provide the information that your practitioner needs to provide care for you.
2. Follow your treatment plan.
3. Provide current and accurate insurance information and inform AWG about any changes in your insurance coverage.
4. Keep all appointments.
5. Give 24-hours notice when you are unable to keep an appointment.
6. Pay co-pay, co-insurance or private pay fee at the time of service.
7. Be certain you have all necessary "pre-authorizations" from your insurance company.
8. Pay fees incurred due to your failure to follow insurance plan rules.

IF THE PATIENT IS UNDER 16 YEARS OF AGE: I acknowledge and agree that I am the parent, custodial parent, legal guardian or other Personal Representative of this patient, and that I have the legal right to make medical decisions for this patient. As a custodial parent, legal guardian or other Personal Representative of this patient, I will provide a copy of any prevailing court order or other legal document (such as, for example, court-approved separation agreement or other temporary order, divorce decree or court order appointing guardianship) verifying my status as having legal responsibility for making medical decisions for the patient and the legal right of access to the child's medical record and/or Protected Health Information (PHI).

I have read these rights and responsibilities, and consent to treatment under these conditions.

_____ _____
Patient Name (printed) Patient Date of Birth

_____ _____
Patient Signature Date Signed

_____ _____
SIGNATURE of custodial parent, legal guardian or other Personal Representative if patient is under 16 years of age Date Signed

_____
Name (PRINTED) of custodial parent, legal guardian or other Personal Representative if patient is under 16 years of age

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Payment Responsibility Contract

I, _____, accept responsibility for payment of charges incurred by _____ (patient name) at Access Wellness Group, Inc.

Signature of party responsible for payment:

_____ Date: _____

Relationship to client ___ Self _____ Parent _____Other: _____

Billing information for Party Responsible for Payment

Last Name: _____ First Name: _____ MI __

SSN: ____-___-____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: ( )_____

Employee Assistance Program

Company Name: _____

Employee Name: _____

Employee SSN: ___-___-___