Wild Wellness Integrative Medicine LLC
405 W Cool Dr. Ste. #105
Oro Valley, AZ 85704
www.wild-wellness.com

All Information is Held in Strict Confidentiality

Patient Name: _____ Age: _____ Marital Status: M S D W

Birth Date: Month ____ Day____ Year_____ Country: USA Other: _____ Sex: M F (circle one)

Permanent Address:_____ Apt. _____

City:_____ State:_____ Zip Code: _____

Current Medications/Supplements:_____

Allergies to Medications: _____

Home
Phone#(required)_____Cell#:_____Work#:_____

e-mail (required):_____

Occupation: _____ Years _____ Employer _____

May we contact you by phone, voicemail, text and e-mail with personal health information? Y/N

May we contact you for marketing purposes? Y/N If yes check: Phone ( ), e-mail ( ), text ( ).

Name of Spouse_____ Are you a Veteran?: Y/N

Emergency Contact: _____ Phone _____

What condition brings you in today? _____

Are you seeking to Certify for Medical Marijuana: Y/N (circle one) (SKIP NEXT IF ANSWERED "NO")

If yes, for which qualifying condition will you be seeking certification?_____

For how long have you had this condition? _____

Are you requesting a caregiver? Y/N (circle one). If yes, caregiver's name: _____

Do you have a current Medical Marijuana Card? Y/N If yes, Patient ID number #:_____

Primary Care Physician_____Phone_____ City_____

Clinic policy requires payment at the time of service. Although the clinic does not bill insurance companies for non-accident related matters, the staff will assist you in helping to receive insurance re-imbursement for medical issues when possible.

I understand and agree that all services rendered, unless otherwise noted, are charged directly to me and that I am personally responsible for payment. Similarly, I understand that if I suspend or terminate my care or treatment, any fees or court costs incurred as a result of collection efforts with be added to my account balance.

I have received and understand the Patient Privacy Act, and all information included therein.

_____ _____

Patient's signature Parent/Guardian Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Wild Wellness Integrative Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Wild Wellness Integrative Medicine, Joshua Reilly, NMD or any associates thereof describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wild Wellness Integrative Medicine, Josh Reilly, NMD (WWIM) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 405 W Cool Dr. Suite 105, Oro Valley, AZ 85704.

With this consent, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, WWIM may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, WWIM may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that WWIM restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow WWIM to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, WWIM may decline to provide treatment to me.

_____

Patient’s signature Parent/Guardian Date