Wellness Center for Older Adults

401 W 16th Street STE 600, Plano, TX 75075

2018-2019 Client Admission Form

Name:_____ Phone: ( )_____/_____

Address: _____ City:_____

State: _____ Zip: _____ County: _____ Male: _____ Female:_____

Birthdate: _____ / _____ / _____ Age: _____ Are you a veteran? Yes _____ No _____

Email:_____

How did you hear about the Wellness Center for Older Adults? _____

Race/Ethnicity:

Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Yes ____ No ____

Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

In Case of an Emergency Please Contact

Name: _____ Relationship: _____

Address:_____ City: _____ State/Zip: _____

Home Phone: ( )_____/_____ Work Phone: ( )_____/_____

I hereby give my permission for the Wellness Center for Older Adults to deliver services to me (or above named adult under my guardianship). By my signature I acknowledge that all information I have provided is true and correct to the best of my knowledge.

Date:_____ Signature:_____

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2017-2018 Client Admission Form

********** **CAREGIVER COUNSELING CLIENTS ONLY** **********

Person(s) of Concern:

Name(s):_____

Address:_____

City:_____ State:_____ Zip:_____

County:_____ Telephone:_____

Relationship to Caregiver:_____

Birthdate:____/____/_____ Age:_____ Race:_____ Male:_____ Female:_____

********** **HEALTHCARE CLIENTS ONLY** **********

Health Care Information

Primary Care Physician:_____

City:_____ State:_____ Ph: ( ) _____/_____

Allergies: _____

_____

Medications:_____

_____

Health Concerns:_____

_____

_____

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Privacy Rule Notification

Dear Client:

The HIPAA (Health Insurance Portability and Accountability Act) 1996 mandated by Congress has created national standards to protect your medical records and other personal health information. This rule enables you to:

- Find out how your health information will be used by the Wellness Center for Older Adults.
- Examine and obtain a copy of your health records and request corrections from the Wellness Center for Older Adults.
- Control certain uses and disclosures of your health information by the Wellness Center for Older Adults.

Client records are secure and available to only those individuals who need them to carry out treatment, payment or healthcare operations and activities. Wellness Center for Older Adults' personnel have access to only the minimum client information that is necessary to do their job. Disclosure is made only to individuals who need to know the information in order to treat the client, conduct the practice's operations, or obtain payment for services. Written authorization is obtained from the client before disclosing information for any purpose other than treatment, payment or practice/facility operations.

I have read and received a copy of the Wellness Center for Older Adults' Privacy Rule Policy.

Client Signature: _____

Date: _____