

# Wellness Center For Older Adults

## 2024-2025 Health Client Admission Form

STAFF USE ONLY

Client ID #:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Gender: \_\_\_\_\_

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Are you a veteran? Yes \_\_\_\_\_ No \_\_\_\_\_

Email: \_\_\_\_\_

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

Are you:  Disabled  Female Head of Household

### Race/Ethnicity:

Do you consider yourself to be Hispanic? Yes \_\_\_\_\_ No \_\_\_\_\_ Also, please select the racial categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply:

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander |
| <input type="checkbox"/> Asian                          | <input type="checkbox"/> White                                  |
| <input type="checkbox"/> Black or African American      | <input type="checkbox"/> Other/Multi-Racial: _____              |

### Health Care Information

Primary Care Physician: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Ph: ( ) \_\_\_\_\_ / \_\_\_\_\_

Medication List Attached: Yes \_\_\_\_\_ No \_\_\_\_\_ If no, list current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Health History/Medical Diagnosis: \_\_\_\_\_

Do we have permission to leave you a phone message regarding health info? Yes \_\_\_\_\_ No \_\_\_\_\_

### In Case of an Emergency Please Notify

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.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**STAFF USE ONLY:** ID Type:  TX DL or ID City: \_\_\_\_\_

Other ID: \_\_\_\_\_ Age Verification: Yes / No Exp. Date: \_\_\_\_\_

ID does / does not match current address. Initials: \_\_\_\_\_

Proof of Current Address Not Provided (bank statement, utility bill or lease) requested on (date) \_\_\_\_\_

Family Member completed Proof of Residency Form on (date) \_\_\_\_\_

*Please see other side for signature*

## **Wellness Center for Older Adults**

### **Client Privacy Rule Policy**

- Client records are available only to those individuals who need them to carry out treatment, payment or healthcare operations and activities.
  
- Wellness Center workers 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 patient, conduct the practice's operations, or obtain payment for services.
  
- A client's written authorization is obtained before disclosing the client's information for any purpose other than treatment, payment or practice/facility operations.
  
- It is our policy that client scheduling books are kept confidential. They will be locked in a secure location when not in use on evenings and weekends.
  
- All conversation regarding clients will be in low speaking voices so that no client information is overheard by other clients.
  
- Clients will sign a consent form for any information being transferred to other providers.
  
- Our fax and e-mail have disclaimers that state that the information is confidential and may be protected by legal privilege. It also states that if the recipient is not for whom it was intended, that they are to be aware that any disclosure, copying, distribution or use of the e-mail/fax or attachment is prohibited. We also ask that if the receiver has obtained the fax/e-mail in error, that they notify us immediately by returning it to the sender and deleting the copy from the system.
  
- It is the Wellness Center's policy to never disclose information about clients without their written consent. We also do not release any patient names/address to anyone for marketing purposes.
  
- Wellness Center workers will not relay any medical information about a client when calling them to be seen by a provider for their appointment.

In the event that a client feels these policies have not been upheld, the client may voice the situation with the Office Manager. Report of an issue may be submitted by the client in writing or verbally. In the event that the client feels appropriate measures regarding their circumstances are not taken by the Office Manager, the client may inform the Executive Director.

I have read a copy of the Wellness Center for Older Adult's Privacy Rule Policy.

I would like a copy of the Wellness Center for Older Adult's Privacy Rule Policy.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_