



Sangeo Wellness Center, LLC
Sandy Sanderson, MSN, APRN, FNP-C

Supervising Physician: Dr. Angela Willis
Phone Number: 931-797-8646 Fax Number: 888-307-0355
Sandymasn2019@gmail.com

PATIENT INSTRUCTIONS FOR PAPERWORK

Thank you so much for trusting your care to Sangeo Wellness Center. We take patient care seriously, and want to ensure you have the best possible experience. Attached are the new patient forms. Please complete all forms entirely and return them by email, mail, or fax. We need to receive this information prior to your first visit in order to have a productive appointment.

Please provide the following documents and information prior to your appointment:

1. Recent lab results and recent medical records
2. Completed medical history form. Typed medical history (if you do not have your medical records)
4. List of symptoms you are currently experiencing
5. List of ALL supplements and medications with dosage that you are taking
6. If you are using bio-identical hormones, please bring actual medication to your appointment

Providing this information will allow you and Sandy to optimize your appointment time to develop your personalized care plan, rather than rebuilding all your health information.

Please be prepared to spend about 1 ½ to 2 hours during your initial visit and 30 – 45 minutes for follow-ups visits.

Please call or email us with any questions or concerns. We look forward to seeing you soon!



PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Cell Phone #: _____ Home #: _____ Work #: _____

Email Address: _____

Sex: M / F Race/Ethnicity: _____

Employer Name: _____ Employer Status: FT/PT/Retired/ N/A

EMERGENCY CONTACT

Contact Name: _____ Phone #: _____

Relationship to Patient: _____

RESPONSIBLE PARTY (IF NOT PATIENT)

Name: _____ DOB: _____

Phone #: _____ Relationship to Patient: _____

Billing Address: _____

City, State, Zip: _____

OTHER INFORMATION

Pharmacy Name: _____

Address: _____

Pharmacy Phone #: _____ Pharmacy FAX: _____

Medical History/Current Problems (Make a list and include date of onset) – What is bringing you in for care? Add additional page if needed.



Surgical History:

Date:

What was done and reason:

Do you have breast implants? Yes or No Date of Surgery: _____

Have you had breast implants in the past? Yes or No Date Removed: _____

Allergies (Medication) – list allergy and type of reaction;

Allergies (Food or Environmental) – list allergy and type of reaction:

All Prescription Medications and Supplements



FAMILY MEDICAL HISTORY

This is a particularly important area of information, please fill it out to the best of your ability. *INCLUDE: age (or age of death), living/deceased, any health issues, cause of death*

Father:

Mother:

Sibling (brother or sister):

Sibling (brother or sister):

Sibling (brother or sister):

Maternal Grandfather:

Maternal Grandmother:

Paternal Grandfather:

Paternal Grandmother:



SOCIAL HISTORY

Occupation: _____

Stress level: _____ Marital Status: _____

Do you feel safe in your home? _____

Does anyone hurt you physically or emotionally? _____

Do you feel safe in your neighborhood? _____

Do you live in a: House/Apt/Homeless Age of Home: _____

Do you have any mold in your home or water leaks? _____

Any lead paint or pipes? _____ Any known asbestos? _____

Exercise (what type/frequency/duration):

Do you follow any special diets? _____

Caffeine (how many cups/amount per day): _____

Alcohol: YES or NO Amount per week? _____

Smoking: YES or NO How many years? _____ How much per day? _____

Any illicit drug use? YES or NO Type/frequency: _____

Recent travel outside the US? _____

Primary Care Provider: _____ Phone #: _____

Other provider/specialist: _____ Phone #: _____

Other: _____ Phone #: _____

OBGYN: _____ Phone #: _____

Date of last PAP smear: _____ Date of last mammogram: _____



Review of Systems (Circle those you have had within the last 2 weeks)

Constitutional

Weight Loss
Weight Gain
Loss of Appetite
Fever
Fatigue

ENT/Respiratory

Cough
Congestion
Nose Bleeds
Hearing Loss
Ringing in Ears
Change in Voice/Hoarseness
Sore Throat
Sinus Pain
Shortness of Breath
Wheezing
Mouth Sores

Cardiology

Decreased Exercise Tolerance
Heart Murmur
Palpitations
High Blood Pressure
Chest Pain
Swelling
Varicose Veins
Poor Circulation

Gastroenterology

Vomiting
Constipation
Diarrhea
Nausea
Blood in Stool
Difficulty Swallowing
Change in Bowel Habits
Heartburn

Genitourinary (Male)

Difficulty Urinating
Nighttime Urination
Dribbling Urine
Hernia
Undescended Testicle
Blood in Urine
Penile Discharge
Genital Sore/Ulcer

Genitourinary (Female)

Irregular Periods
Heavy Periods
Painful Periods
Pelvic Pain
Painful Urination
Blood in Urine
Urinary Frequency
Nighttime Urination
Vaginal Discharge
Genital Sor/Ulcer

Ophthalmology

Decreased Vision
Eye Irritation or Discharge
Dry Eyes
Blurred Vision
See Spots or Floaters
Sudden Vision Loss

Hematology/Lymphatic

Bruise Easily/Excessive Bruising
Swollen Lymph Nodes
Bleed Easily

Endocrinology

Excessive Thirst
Excessive Hunger
Excessive Urination
Excessive Sweating
Heat Intolerance/Hot Flashes
Cold Intolerance

Musculoskeletal

Joint Pain/Stiffness
Joint Swelling
Sciatica
Fracture
Back Pain
Neck Pain

Psychology

Depression
Anxiety/Panic Attacks
Sleep Disturbance/Insomnia
Irritability
Mood Swings
Mental/Physical/Sexual Abuse
Excessive Energy
Trouble Staying on Task
Loss of Interest in Usual Activities

Neurology

Weakness
Numbness/Tingling
Headache
Dizziness
Balance Problems
Memory Loss/Forgetfulness

Dermatology

Rash
Acne
Change in Size/Shape of Moles
Lumps
Dry or Sensitive Skin
Tattoos
Facial Hair (females)
Itchy Skin
Brittle Nails/Splits in Nails
Clubbed Fingernails



Sandy Sanderson, MSN, APRN, FNP-C

Phone Number: 931-797-8646 Fax Number: 888-307-0355

Sandymn2019@gmail.com

Release Of Information

Patient Name (please print): _____

Date of Birth: _____ Phone #: _____

Address: _____

I, the undersigned, authorize you to furnish a copy of my medical records to:

_____ Sangeo Wellness Center or to _____

We are requesting medical records for the patient named above to be sent TO/ FROM the medical provider named below:

Provider Name: _____

Specialty: _____

Address: _____

City, State and Zip: _____

Phone Number: _____ Fax number: _____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, genetic testing, or AIDS information. I, the undersigned, have read the above and authorized the staff of the specified facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Medical Information". This order will remain in effect until revoked by me in writing.

Signed: _____ Date: _____

Relationship to Patient if not self: _____

PLEASE RETURN A COPY OF THIS FORM WITH RECORDS



Advanced Beneficiary Notice

NOTE: You must make a choice about receiving these laboratory tests, procedures and/or purchasing supplements.

By signing this acknowledgement, you understand there are procedure, laboratory tests and supplements which may not be paid for by your health insurance companies, and if you chose to receive them, you will be responsible for payment for these procedures, supplements and any additional testing.

Sandra Sanderson, NP cares for patients with acute and chronic ailments utilizing a bio-medical approach that is an integration of both traditional medicine and validated complimentary techniques and treatment strategies. As a result, some of the tests utilize labs that are out of network for your health plan; and some procedures and certainly none of the supplements are covered by your plan.

We expect that your Health Insurance Provider will not pay for the laboratory test(s), procedures or the supplements that are described below.

Your Health Insurance Provider may or may not pay for:

- Alletess- Food Sensitivity
- ZRT Saliva Testing for Hormones and Adrenals
- Precision Analytical DUTCH Testing for Hormone and Adrenal
- Spectracell Nutrient Testing
- 3X4 Genetic Testing
- Genova Labs GI Effects Stool Testing
- Mosaic Diagnostics – MycoTOX
- Mosaic Diagnostics – Organic Acid Test

You may submit the costs of any lab tests to your insurance company. We will provide you with the documentation to help you do this. However, the insurance company may pay a fraction of your expenses, or none at all. You cannot file for the cost of supplements purchased or for certain procedures that are listed (if applicable). These procedures include but are not limited to the administration of IV vitamin/minerals and/or the injections of vitamins. These procedures must be paid for at the time of your office visit.

[] Option 1. YES. If I choose to receive these items or services. I understand that I am responsible for payment of these services directly to service provider. The service provider may be able to file your insurance, but Sangeo Wellness Center will not participate in that billing process and is not responsible for non-covered services. I understand I will work directly with service provider to resolve any billing disputes. I also understand that any supplements purchased are not covered by insurance and I agree not to file a claim for medical reimbursement.

[] Option 2. NO. I have decided not to receive these items or services.

***PLEASE CHOOSE ONE OPTION AND CHECK IT ACCORDINGLY. SIGN & DATE.**

Signature of patient or representative: _____ Date: _____



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal



activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information.

We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – you have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You have the right to request an amendment to your protected health information – if we deny your request for amendment, you have the right to file a statement of



disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. You have the right to receive notice of a breach – we will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER: Sandy Sanderson

Phone: 931-797-8646

Email: sandymn2019@gmail.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of SANGEO WELLNESS CENTER Notice of Privacy Practices. By signing below, I am “only” giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Print Name



How did you hear about us?

Who can we thank for your referral? _____ Doctor _____ Patient _____ Pharmacy _____ Social Media
_____ Other

Name: _____

RECOGNITION OF INFORMATION AND ACCURACY

***Initials _____** *Please initial that you have received the information and that you have submitted to us the correct and accurate information above to the best of your knowledge.

***Initials _____** *I am the patient or the legal guardian or representative of the patient. "I", "my" in this document refers to me as the patient or legal guardian or representative of the patient. I hereby authorize the assignment of benefits (payments) directly to Sangeo Wellness Center for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with collection. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

***Initials _____** *I have received a copy of the HIPAA Notice of Privacy Practices.

Signature of Responsible Party: _____ Date: _____

Signature of Witness: _____ Date: _____



**Medical Information Release Form
(HIPAA Release Form)**

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

you have permission to send SMS text messages

Other _____

The best time to reach me is (day): _____ between (time): _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____



CLINIC FINANCIAL POLICY

Thank you for choosing us as a healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is part of your treatment. The following is our Financial Policy that we require you to read and sign.

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance and understanding of our payment policy:

Full payment for professional services is due at time of service. We accept cash, checks (with ID) or Visa/MasterCard/Discover/AmEx, Health Savings and Flexible Spending accounts. There will be a charge of \$50 for returned checks and future checks will not be accepted.

The first visit, a 90-minute appointment, with Sandy is \$500. Follow up visits, including phone consults, cost \$200 and are 30 minutes. We do not take insurance, but we can provide a receipt for your visit if you want to file for benefits yourself. (Sangeo Wellness Center is out of network for every insurance since we are a direct-pay practice, so check your Out-of-Network benefits to see what they are.) Sandy typically orders laboratory and/or specialized testing as a part of our comprehensive and follow up evaluations.

*Initial here [] Lab coverage is based on insurance. Labs are not included in the cost of our visits. Sangeo Wellness Center has no control over what your labs cost, and you are free to decline any lab that Sandy has ordered at any time. Payments for these tests are also due in accordance with your insurance lab billing. Please check with your insurance prior to your lab draw regarding preferred lab and required deductibles and co-insurance you will be responsible to pay.

In order to keep our fees to a minimum, payment is required at the time of service. We require a credit card number at the time of booking, and we will keep this number on file. This information is stored in a password protected computer and would only be charged in the event of a No-Show or late cancellation with less than 24-hour notice.

*Initial here [] Please give us 24-hour notice in advance if you cannot keep your appointment for any reason.

There is a \$100 No-Show/late cancellation fee for follow-ups and \$250 No-show/late cancellation fee for new patient visits. This policy will be enforced.

Signature of Patient/Responsible Party: _____ Date: _____

Signature of Practice Manager: _____ Date: _____

