GCU
CANYON HEALTH AND WELLNESS CLINIC

Name: _____ Date of Birth: (M) __/ (D) ___/(Y) _____
(Last Name) (First Name) (Middle Name)

Address: _____
(Street) (City) (State) (Zip Code)

Cell Phone: _____ Email: _____

Emergency Contact: _____ Relationship to patient: _____

Emergency contact phone number: _____

Office visits are not billed to insurance. Insurance information will be used for send-out laboratory services or radiology services. It is the patient's responsibility to understand their insurance benefits prior to any services performed.

Insurance Company Name: _____
Policy/Member ID number: _____
Group number: _____
Name of Policy Holder: _____
Policy Holder DOB: _____ Relationship to patient:_____

Insurance Address (see back of insurance card): _____

Authorization & Assignment

I hereby authorize Canyon Health and Wellness Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Canyon Health and Wellness Clinic is not responsible for payment to outside labs for tests provided to me.

Patient Name (please print): _____

Patient Signature: _____ **Date**: _____

Personal Medical History (Check box (es) that apply)

ADD/ADHD		**Depression/Anxiety**		**Hepatitis**		**PCOS**		**Tuberculosis**			
Asthma		**Diabetes**		**Irritable bowel syndrome**		**Seizures**		**Other, please specify: 1:**			
Cancer		**Epilepsy**		**Mononucleosis**		**Stroke**		**2:**			
Concussion		**Heart condition**		**Paralysis**		**Thyroid**		**3:**			

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Please circle the corresponding answer and provide comments as needed:

Are you allergic to any medications? **Yes / No** If yes, please list medication and reaction: _____
_____

Do you have any food/ environmental allergies? **Yes / No** If yes, please specify allergy and reaction:
_____

Are you being followed by a physician for any medical condition(s)? **Yes / No** If so, please specify:
_____
_____

Do you take medications on a regular basis (daily or weekly)? **Yes / No** If yes, please list medication, dose and how often you take the medication: _____
_____

Have you been hospitalized or undergone any surgical procedure? **Yes / No**
If yes, please list year, illness and/or type of surgery: _____
_____

Are you currently being treated or have you been treated for any psychological/emotional issues, or eating disorders? **Yes /No** If yes, please list reason and year (s): _____
_____

Family Medical History

Family Member	Age	General Health: Good/Poor?	Past/Present Serious Illness	If Deceased, at what age?	Cause of Death
Father					
Mother					
Brother/Sister					
Brother/Sister					

SEXUAL HISTORY

Please circle the corresponding answer and provide comments as needed:

Are you sexually active? **Yes / No**
If yes, number of total partners: _____
Are you currently engaging in sexual behaviors with current partner? **Yes / No**
If so, what are you preferred sexual activities: _____
Are your sexual partners: Male: _____Female: _____Both: _____
Have you ever contracted a sexual transmitted infection/disease? **Yes / No** If yes, please specify: _____
_____
How often do you practice safe sex? Always: _____ Sometimes: _____Never: _____

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What method of safe sex do you practice? Condoms: ____ Birth control pill: ____
Other (specify):_____

WOMAN ONLY: Date of last menstrual period: _____Date of last Pap smear: _____
Date of last mammogram? _____
Are you currently using a birth control method? Yes: _____No: _____If yes, type: _____

MEN ONLY: Do you perform monthly testicular exams? _____

Social History

Do you smoke? **Yes / No** If yes, number of cigarettes per day: _____
Do you drink alcohol? **Yes / No** If yes, number of drinks per week? _____
Do you consume caffeinated drinks? **Yes / No** If yes, number of drinks per week? _____

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More Than half**	**Nearly every day**
1. Little interest or pleasure in doing thing	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

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Medical Information Release Form

(HIPAA Release Form)

My health record is private and is known under the law as "Protected Health Information (PHI)". By completing this form I agree to allow Canyon Health and Wellness Clinic to share my PHI with the people below.

Release of Information

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

[ ] Parent or legal guardian: _____
[ ] Other_____
[ ] Information is not to be released to anyone.

The ***Release of Information*** form will remain in effect for 1 calendar year from the date it was originally signed.

If I am unable to be reached by phone, a detailed message may be left on: [ ] home [ ] work [ ] cell
Phone number: _____
If unable to reach me:

[ ] please leave a detailed message
[ ] please leave a message asking me to return your call
[ ] please contact me via secured student portal

Patient signature: _____ **Date**: ____/____/_____

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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.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of GCU Canyon Health and Wellness Clinic. For example, your information may be used to evaluate care, for accreditation, and to promote quality at GCU Canyon Health and Wellness Clinic.

Law Enforcement. Your health information may be disclosed to law enforcement agencies or governmental agencies to comply with legally required or government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

ADDITIONAL USES OF INFORMATION

GCU Canyon Health and Wellness Clinic staff who telephones you for appointment reminders will have access to your health information for that purpose. We may also send you information describing treatment alternatives and other health-related products and services that we believe may interest you.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION

Disclosure of your health information or its use for any purpose other than those listed in this Notice requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

INDIVIDUAL RIGHTS

You have the right to expect the following from us:

- The right to request in writing restrictions on the use and disclosure of your protected health information (The Canyon Health and Wellness Clinic will review all requests and normally will respond within 60 days, but is not required to agree)
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

GCU CANYON HEALTH AND WELLNESS CLINIC

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised polices and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. We require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the GCU Canyon Health and Wellness Clinic. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Legal Department
Grand Canyon University
P. O. Box 11097 Phoenix, Arizona 85061-1097
ph# (602) 639-6656

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also send a written complaint to the Secretary of the Department of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

If you have any questions about this notice or our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the GCU Legal Department at the address or telephone number listed above.

I have received a copy of the Notice of Privacy Practices for GCU Canyon Health and Wellness Clinic.

_____

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Name of Patient (Please Print)

Signature of Patient **Date**

Signature of Patient Representative **Date**
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient