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PATIENT REGISTRATION FORM

Personal Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Social Security Number (Optional): _____

Marital Status: _____

Occupation: _____

Contact Information:

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Emergency Contact Information:

Full Name: _____

Relationship to Patient: _____

Phone Number: _____

Insurance Information:

Primary Insurance Company: _____

Insurance Policy Number: _____

Group Number (if applicable): _____

Insurance Phone Number: _____

List any current medications (prescription and over-the-counter):

_____

_____

_____

_____

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Immunization Record:
Please provide information on the most recent vaccinations received:
Vaccine Name: _____ Date Administered: _____
Vaccine Name: _____ Date Administered: _____
Vaccine Name: _____ Date Administered: _____
Vaccine Name: _____ Date Administered: _____
Preferred Pharmacy:
Pharmacy Name: _____
Pharmacy Address: _____
City: _____ State: _____ Zip: _____

Phone Number: _____
Consent and Authorization:
By signing below, I certify that the information provided in this Patient Registration Form is accurate and complete to the best of my knowledge. I authorize Kutendo Health to use this information for medical treatment, billing, and administrative purposes.
I also authorize the release of my medical records to and from other healthcare providers as needed for continuity of care.

Signature: _____
Date: _____

HIPAA AUTHORIZATION

I, _____, hereby authorize Kutendo Health to use and disclose my protected health information (PHI) for the purposes described below:
Purpose of Disclosure:
[ ] Treatment: I authorize the use and disclosure of my PHI for the purpose of providing medical treatment and healthcare services to me. This may include sharing information with
healthcare professionals, laboratories, and other entities involved in my care.
[ ] Payment: I authorize the use and disclosure of my PHI for the purpose of obtaining payment for
healthcare services rendered to me. This may involve sharing information with my insurance company or
other third-party payers.
[ ] Healthcare Operations: I authorize the use and disclosure of my PHI for the purposes of healthcare operations, such as quality improvement, staff training, and administrative activities that support the provision of healthcare services.
Description of Information to be Disclosed: The information that may be disclosed includes, but is not limited to, my medical history, diagnosis, treatment plan, medications, test results, and any other information related to my healthcare.

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Description of Information to be Disclosed: The information that may be disclosed includes, but is not limited to, my medical history, diagnosis, treatment plan, medications, test results, and any other information related to my healthcare.
Persons Authorized to Disclose and Receive Information: I authorize Kutendo Health and its authorized representatives, including healthcare providers and staff, to disclose and receive my PHI as necessary for the purposes described above.
Duration of Authorization: This authorization shall be valid from the date signed below and will remain in effect until Expiration Date or Event, if applicable. I understand that I have the right to revoke this authorization in writing at any time, except where the use or disclosure of my PHI has already occurred based on this authorization.
Right to Revoke Authorization: I understand that I have the right to revoke this authorization at any time by submitting a written request to Kutendo Health. However, I acknowledge that revoking this authorization may limit or prevent certain healthcare services or payments.
HIPAA Notice of Privacy Practices: I have received and read Kutendo Health's Notice of Privacy Practices, which explains how my PHI may be used and disclosed, as well as my rights related to my PHI. I understand that I have the right to obtain a copy of this Notice upon request.
Electronic Signature: By signing below, I acknowledge that I have read and understand the contents of this HIPAA Authorization Form. I voluntarily provide my authorization for the use and disclosure of my protected health information as described above.

Signature: _____ Date: _____

TELEMEDICINE CONSENT

I, _____, hereby provide my consent for telemedicine consultations with Kutendo Health. Telemedicine refers to the use of audio, video, and other electronic communication technologies to facilitate medical consultations between patients and healthcare providers remotely.
Benefits of Telemedicine: I understand that telemedicine consultations offer certain benefits, including:
Convenience: The ability to consult with healthcare providers from the comfort of my home or other suitable locations.
Timeliness: Reduced wait times for appointments and immediate access to medical advice when needed.

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Continuity of Care: Access to medical services even during travel or when facing mobility challenges.
Reduced Exposure: Minimized exposure to contagious illnesses, especially during public health emergencies.
Limitations of Telemedicine: I acknowledge that telemedicine consultations have certain limitations, including:
Technical Issues: Potential technical challenges or interruptions during the virtual consultation.
Limited Physical Examination: The inability to perform a comprehensive physical examination compared to in-person visits.
Prescription Limitations: Prescription of certain medications may be restricted, and controlled substances may not be prescribed via telemedicine.
Emergency Situations: Telemedicine may not be appropriate for emergencies or life-threatening conditions.
Privacy and Security: I understand that Kutendo Health uses secure and encrypted telemedicine platforms to protect the privacy and confidentiality of my health information. I have received and read Kutendo Health's Notice of Privacy Practices, which outlines how my protected health information (PHI) will be used and disclosed during telemedicine consultations.
Alternative Options: I acknowledge that I have the option to seek in-person medical instead of telemedicine, and I can choose to discontinue telemedicine services at any time.
Insurance Coverage: I understand that telemedicine services may be covered by my insurance plan.However, I am responsible for verifying telemedicine coverage with my insurance carrier.
Costs and Billing: I agree to pay for telemedicine services rendered to me by Kutendo Health based on the standard fee schedule. I will be responsible for any applicable copayments, deductibles, or other fees associated with telemedicine consultations.

Electronic Signature: By signing below, I acknowledge that I have read and understand the contents of this Telemedicine Consent Form. I voluntarily provide my consent for telemedicine consultations with Kutendo Health.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I, _____, understand and acknowledge that I am financially responsible for all healthcare services rendered to me by Kutendo Health. I agree to comply with the following financial terms and conditions:

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Insurance Coverage: I understand that Kutendo Health does not accept insurance. I acknowledge that I am ultimately responsible for all charges associated with care.
Self-Pay Patients: I understand that all patients are self-pay. I agree to pay for all services rendered at the time of my visit. Kutendo Health will provide me with an itemized statement detailing the services and associated charges.
Payment Terms: I agree to make payment for all outstanding balances within 30 days from the date of the invoice. Accepted forms of payment include cash, check, credit/debit card, or other methods specified by Kutendo Health. I understand that if using a debit or credit card that there is a service fee.
Missed or Late Appointments: I understand that failing to cancel or reschedule appointments at least 24 hours in advance may result in a missed appointment fee. I agree to be responsible for such fees, as determined by Kutendo Health's policies.
Collections and Attorney Fees: In the event that my account becomes delinquent and is referred to a collection agency or attorney for collections, I agree to be responsible for any associated fees and costs incurred by Kutendo Health.
Insurance Claims Assistance: I understand that Kutendo Health does not provided insurance claim assistance. I understand that the final resolution of the claim and any payment or denial of benefits are the responsibility of my insurance carrier.
Financial Hardship and Payment Plans: If I experience financial hardship and have difficulty paying my medical bills, I understand that I can discuss payment plan options with the clinic's billing
department.
Electronic Signature: By signing below, I acknowledge that I have read and understand the contents of this Financial Responsibility Form. I voluntarily agree to assume financial responsibility for all healthcare services provided to me by Kutendo Health.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

Purpose and Scope: I, _____, hereby consent to receive medical services and treatment from Kutendo Health LLC. I understand that this consent form covers health and wellness services provided by licensed medical professionals within the clinic. These services may include, but are not limited to, routine check-ups, preventive care, vaccinations, diagnostic tests, and minor medical
procedures.
Provider-Patient Relationship: I understand that by signing this consent form, I am entering into a provider-patient relationship with the medical professionals at Kutendo Health LLC. I acknowledge that I am free to seek medical care from other healthcare providers and that I have the right to discontinue services at any time, subject to applicable laws and regulations.

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Treatment Authorization: I authorize the healthcare professionals at Kutendo Health to examine, diagnose, and provide necessary medical treatment, including administering medications and vaccinations, as deemed appropriate for my health and well-being. I understand that the proposed treatments will be discussed with me before any procedure or intervention is undertaken.

Confidentiality and HIPAA: I acknowledge that my medical records and personal health information are protected by federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). I authorize the disclosure of my medical records to other healthcare providers, as required for my continuity of care, and to my insurance company for billing purposes.

Informed Consent: I understand that the healthcare professionals at Kutendo Health LLC will explain the nature, risks, and benefits of any proposed medical treatment or procedure before obtaining additional specific informed consent. I understand that Kutendo Health LLC does not treat patients using the traditional medical model. I acknowledge that I have the right to ask questions and seek further information before providing consent to any medical intervention.

Insurance and Financial Responsibility: I agree to provide accurate and up-to-date insurance information to Kutendo Health LLC. I understand that I am responsible for full payment of services rendered at the time of my visit. I understand that Kutendo Health LLC does not accept insurance.

Release and Indemnification: I release and discharge Kutendo Health LLC its medical staff, employees, and affiliates from any liability arising from medical services and treatments provided to me. I agree to indemnify and hold Kutendo Health LLC harmless from any claims, actions, or damages arising from my receipt of medical care at the clinic.

Consent for Minors: For patients under the age of 18, I confirm that I am the parent or legal guardian of the minor named above and that I have the authority to provide this consent on their behalf.

By signing below, I acknowledge that I have read and understand the contents of this consent form. I voluntarily and willingly provide my consent to receive medical services at Kutendo Health LLC.

Signature: _____Date: _____

APPOINTMENT REMINDER CONSENT

I, _____,hereby provide my consent to receive appointment reminders from Kutendo Health via various communication methods, including but not limited to phone calls, text messages, and emails.

Purpose of Appointment Reminders:

The appointment reminders serve the following purposes:

1. To help me remember upcoming scheduled appointments at Kutendo Health.
2. To ensure that I receive timely notifications about any changes or updates to my appointments.

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Frequency of Reminders:
I understand that appointment reminders may be sent at appropriate intervals before my scheduled appointments, as determined by Kutendo Health's policies and scheduling practices.

Contact Information:
I authorize Kutendo Health to use the contact information provided above to send appointment reminders. I will promptly update Kutendo Health if there are any changes to my contact information.

Opting Out:
I have the right to opt-out of receiving appointment reminders at any time. If I wish to stop receiving reminders, I will inform Kutendo Health in writing or by calling the clinic at 317-863-9366.

Limitations
I acknowledge that appointment reminders are an additional service provided for my convenience, but I am responsible for keeping track of my appointments and ensuring that I attend them as scheduled.

HIPAA Authorization
I understand that my contact information will be used in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations. I authorize Kutendo Health to use my contact information solely for the purpose of appointment reminders and scheduling.

Electronic Signature
By signing below, I acknowledge that I have read and understand the contents of this Appointment Reminder Consent Form. I voluntarily provide my consent to receive appointment reminders from Kutendo Health.

Signature: _____
Date: _____

Please Note:
- This Appointment Reminder Consent Form will remain in effect until revoked in writing or until the purpose of the appointment reminders is fulfilled.
- If you have any questions or need assistance, please feel free to ask our staff at Kutendo Health. Your satisfaction is our priority. Thank you for choosing Kutendo Health for your healthcare needs.

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HEALTH HISTORY
Medical History: Please check any existing medical conditions or health issues:
[ ] Hypertension [ ] Diabetes [ ] Asthma [ ] Allergies (Please specify): _____
[ ] Heart Disease [ ] Thyroid Disorder [ ] Chronic Pain (Please specify): _____
[ ] Respiratory Conditions (Please specify): _____
[ ] Digestive Issues (Please specify): _____
[ ] Autoimmune Conditions (Please specify): _____
[ ] Mental Health Conditions (Please specify): _____
[ ] Other (Please specify): _____
Surgical History: Please list any past surgeries, including the date and type of surgery:

Family Medical History: Please provide information on any significant medical conditions or illnesses that run in your immediate family (parents, siblings):

Allergies: Please list any known allergies to medications, foods, or other substances:

Lifestyle and Habits:

How would you describe your current stress level?
[ ] Low
[ ] Moderate
[ ] High

How many hours of sleep do you typically get per night?
[ ] Less than 5 hours
[ ] 5 to 7 hours
[ ] 7 to 9 hours
[ ] More than 9 hours

Do you engage in regular physical activity or exercise?
[ ] Yes
[ ] No
If yes, please specify the type and frequency of exercise: _____

How would you rate your overall diet and nutrition?
[ ] Excellent
[ ] Good
[ ] Fair
[ ] Poor

Do you smoke or use tobacco products?
[ ] Yes
[ ] No
If yes, please specify the frequency and amount: _____

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How much alcohol do you consume per week?
[ ] None
[ ] Occasional
[ ] Moderate (1-2 drinks per day)
[ ] Heavy (3 or more drinks per day)

Do you have any specific dietary restrictions or food allergies?
[ ] Yes
[ ] No
If yes, please specify: _____
Women's Health (if applicable): [ ] Pregnant [ ] Breastfeeding [ ] Menopause
Wellness and Health Goals:

What are your primary wellness and health goals?
Are there any specific health concerns or symptoms you would like to address?
Have you experienced any recent changes in your health or well-being?

Other Relevant Information: Please provide any other information that you believe is important for your healthcare provider to know:

Consent and Authorization: By signing below, I certify that the information provided in this Health History Form is accurate and complete to the best of my knowledge. I understand that this information will be used for medical evaluation, diagnosis, and treatment purposes. I also authorize Kutendo Health to release and obtain medical records related to my health history from other healthcare providers as needed for continuity of care.
Electronic Signature: Signature: _____ Date: _____

Please Note:
- The information provided in this form will be kept confidential and used solely for healthcare purposes.
- It is essential to keep your contact and insurance information up to date. Please notify the clinic of any
changes promptly.
- If you have any questions or need assistance, please feel free to ask our staff at Kutendo Health.

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