Travel Immunization Intake Form

Today's Date: ____________________

Client Information

Last Name: ______________________ First: ______________________ MI: ______

DOB: ______________ Age: __________ Phone: ______________________

Street Address: ____

PO Box: ________ City: ______________________ State : ______________ Zip: ________

Email Address: ____

Travel Information

Reason For Travel: [ ] Business [ ] Pleasure [ ] Church / Missions [ ] Other: ______________

Organization Name: ______________________ Date of Departure: ______________

Destination (list in order)	**Area Type**	**Length of Stay**
______________________	[ ] Rural [ ] Urban	______________
______________________	[ ] Rural [ ] Urban	______________
______________________	[ ] Rural [ ] Urban	______________
______________________	[ ] Rural [ ] Urban	______________
______________________	[ ] Rural [ ] Urban	______________

Medical Information

Are you allergic to any medications? [ ] Yes [ ] No List: ______________________

To your knowledge, are you allergic to any insect stings / bites? [ ] Yes [ ] No List: ______________

Do you suffer from any chronic illness? [ ] Yes [ ] No List: ______________________

Do you have egg hypersensitivity? [ ] Yes [ ] No

Have you been vaccinated in the past 28 days? [ ] Yes [ ] No List: ______________________

Please list all current medications (including over the counter): ______________________

____

Women:

Are you pregnant? [ ] Yes [ ] No Are you breast feeding? [ ] Yes [ ] No Are you experiencing fever? [ ] Yes [ ] No

Acknowledgement

The above information is true to the best of my knowledge. **I understand that I am financially responsible for my balance on any charges incurred and that all travel vaccinations are to be paid for at the time of service.** I authorize WellQuest to release any information required to process my medical claims. In the event that I incur charges that are filed with my health insurance, I authorize my insurance benefits be paid directly to the physician.

Client Name: ____
(Please Print)

Client Signature: ______________________________ Date: ______________

WellQuest Medical & Wellness
3400 Southeast Macy Road #18
Bentonville, Arkansas 72712
P: 479-845-0880 F: 479-845-0887

Travel Vaccine Intake Form

Patient Notice of Our Privacy Practices

Please review the following notice that describes how medical information about you may be used and disclosed and how you may get access to this information.

This is NWA Primary Care Physicians ("Clinic's") notice to you of how certain health information regarding you may be used or disclosed by this Clinic. We are required by law to provide you with a description of our privacy practices. Should you have any questions concerning this Notice, contact the Privacy Officer named below:
• The effective date of this Notice is April, 2003. You will be provided, either by mail or in person with a copy of any amendments or changes to this Notice.
• This Notice should be delivered to you no later than the date of the first encounter with you as a patient or, in an emergency situation, as soon as possible after the emergency treatment situation.
• This Clinic is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to your protected health information.
• Should you believe that your privacy rights have been violated, you have the right to file a complaint with the privacy Officer or with the Secretary of Health and Human Services at the address set forth below. Complaints should be in writing with a description of the events under which you believe your privacy rights were violated. Please give us as much detail as possible in your complaint. This will help us investigate your complaint. It is our policy not to retaliate against any patient for filing a complaint involving a violation of their privacy rights.

Privacy Practices
Disclosure of Your Health Information by Us - We may use or disclose your protected health information for purposes of treatment, payment or healthcare operations without your consent or authorization. This information may be transmitted by electronic transmission, by fax transmittal or by e-mail.
Treatment - "Treatment" is defined by the Department of Health and Human Services in its Privacy Standards as "...provisions, coordination, or management of health care or related services by one or more health care providers..." This means that for our own purposes we may use or disclose protected health care information among our employees and other staff professionals of the Clinic for the purpose of treating your medical condition. Furthermore, we may disclose your protected health information to other health care providers if we make a referral or if we seek consultation or review by another health care provider. An example of treatment might include a situation where your treating physician orders blood work or other types of diagnostic tests. The results of these tests might be reviewed by different professionals or caregivers and their conclusions would be used to assist in determining the appropriate therapies or plan of care for your treatment.
Payment - "Payment" is a rather broad term. An example of a "disclosure or use of protected health care information" for payment purposes would be submitting a claim to your insurance carrier so as to be reimbursed for our services. Other examples include activities such as determining eligibility of coverage under your insurance plan or answering questions by your insurance company so as to determine whether there was a medical necessity for the procedure or diagnosis performed by us or at our direction.
Health Care Operational - The final category under which we may use or disclose your protected health information without your permission is for activities performed by us such as quality assessment, case management and care coordination, contacting other providers about care alternatives for you, conducting internal training programs for supervisory purposes, and activities associated with the licensing and issuance of credentials for our staff.

Our Contacts with You
Periodically, we will issue appointment reminders, provide follow-up information on treatment alternatives, and possibly offer other treatment-related services to you. Typically, we conduct these contacts by mail and telephone. If you do NOT wish us to leave messages on your telephone answering machine or to receive mail at your residence, contact us. You do have the right to ask us to contact you in a confidential manner and we will do our best to accommodate you.

Disclosure to Others
You will be asked to sign protected health information than payment, treatment or to disclose your something other always have the right to revoke an authorization at any time, except to the extent this Clinic or any other providers have already taken an action in reliance upon your authorization.

Disclosures Without Your Consent or Authorization
Under Arkansas law, there are specific conditions or events that must be disclosed to third or state agencies whether or not you authorize this use or disclosure. These categories include:
(a) Incidents of suspected child abuse;
(b) Sexual assaults;
(c) Knife or gunshot wounds;
(d Domestic violence; and
(e) Sudden death of child.
In addition, Clinic participates in clinical research studies, which may involve your treatment. From time to time, we review our patients' protected health information to determine if they are suitable candidates to participate in clinical research trials. Before we will enroll you in such a research program or disclose your protected health information to third parties conducting clinical research trials, we will obtain your express authorization.
Your authorization, will, among other things, contain:
(a) A description of the extent to which your protected health information will be used or disclosed to other persons; and
(b) A description of any protected health information that will not be used or disclosed for purposes of or use in the clinical research trial.
As with any other authorization, you may revoke this authorization at anytime and ask that your protected health information no longer be used as part of the clinical research trials.

Patient Individual Rights
You have the following rights which may be exercised by you at anytime:
(a) The right to request restrictions on certain use and disclosure of your protected health information. However, please note that we will not be required to agree to these restrictions, particularly if, in our opinion, they interfere with treatment, payment, or other health care operations. However, we are willing to work with you in good faith to implement any restrictions you request. Should we disagree with the restrictions you place upon us, we will notify you in writing and suggest alternatives including seeking another health care provider.
(b) You have the right to receive communications from us in a confidential manner as noted above.
(c) You have the right to inspect a copy of your health information in our file at anytime.
(d) You have the right to amend incorrect or incomplete information or to provide a statement as to the reasons you believe the amendment regarding incorrect or incomplete information should be included in your file. However, we are not able to amend or alter health information about you we receive from another health care provider.
(e) You have the right to receive an accounting from us of all your protected health information made to third parties treatment, payment, or health care operations purposes. However, this accounting will be subject to certain restrictions and limitations as set forth below.

Restrictions with Regard to Accounting
Your right to an accounting will riot include the matters set forth below. An accounting with regard to your personal health information will NOT include items:

- Internal use by us of your information for treatment, payment or health care operations purchases.
- Disclosures made to you by us or at your request (or the request of your personal representative) to third parties.
- Disclosures made by you to our answering service or directory service when you contacted us after hours.
- Disclosures made to family members or friends in the course of providing care to you.
- Disclosures to correctional institutions.
- Disclosures made by us for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure by us for a specified period of time.
- Disclosures made to the Department of Health and Human Services, if you have filed a complaint with that organization believing that your privacy rights have been violated.
- Your right to receive a paper copy of this Notice, even if you have previously agreed to receive this Notice electronically.

Questions & Concerns
For more information or to file an internal complaint, contact the Privacy Officer.

Privacy Officer
WellQuest Medical & Wellness
3400 SE Macy, Suite 18
Bentonville, AR 72712
Phone: (479) 845-0880
Fax: (479) 845-0887

The Privacy Officer listed above can provide you with the appropriate address for the United States Department of Health & Human Services.

WellQuest Medical & Wellness
3400 Southeast Macy Road #18
Bentonville, Arkansas 72712
P: 479-845-0880 F: 479-845-0887

Travel Vaccine Intake Form

Today's Date: ____________________

Nurse Checklist

Client Name: ____

Temperature: ________ ^{0}F Heart Rate: ________ bpm Blood Pressure: _______ / _______

[ ] Destination confirmed with client

[ ] Client information reviewed, including current immunization records (nurse to assume routines up-to-date if not provided)

[ ] CDC travel website disclosed to client, destination recommendations reviewed

[ ] Current travel notices provided to client

[ ] Recommended immunizations discussed with client and administered

[ ] Immunization card given to patient, or updated

[ ] Declination of recommended vaccinations listed and initialed by client below

[ ] Destination cautions as disclosed by the CDC discussed with the client

[ ] Client counseled as to the signs and symptoms of malaria

[ ] Client counseled regarding personal protective measures against mosquito bites

[ ] Client counseled as to completion of medication after returning home

[ ] Client counseled as to possible side effects of applicable injections

List of Recommended Vaccinations RECEIVED Today:

Vaccine Name: ______________________________ Given By: ____________________

Vaccine Name: ______________________________ Given By: ____________________

Vaccine Name: ______________________________ Given By: ____________________

Vaccine Name: ______________________________ Given By: ____________________

Vaccine Name: ______________________________ Given By: ____________________

Vaccine Name: ______________________________ Given By: ____________________

List of Recommended Vaccinations DECLINED Today:

Vaccine Name: ______________________________ Client Initials: __________

Vaccine Name: ______________________________ Client Initials: __________

Vaccine Name: ______________________________ Client Initials: __________

My signature implies that I have received all of the above listed information and counsel, both verbally and in hard copy. I understand that I have the opportunity to ask questions and that I understand all of the information shared with me today.

Client Signature: ______________________________ Date: ____________________

Nurse / Provider Signature: ______________________________ Date: ____________________

[ ] Client walked to front desk for payment

WellQuest Medical & Wellness
3400 Southeast Macy Road #18
Bentonville, Arkansas 72712
P: 479-845-0880 F: 479-845-0887