BECKLEY HEALTH RIGHT

111 RANDOLPH STREET
BECKLEY, WV 25801
304-253-3577 OR 304-253-4600

24-HOUR NUMBER FOR NON-EMERGENCY CLINIC CONTACT:
304-890-9339

OPERATING HOURS:
MONDAY - FRIDAY
9:00 am to 5:00 pm

You will need to fill out the 4 page application and return it to the clinic along with:

Photo ID
Proof of Income
Insurance Card

BECKLEY HEALTH RIGHT

2025 PATIENT REGISTRATION FORM

Patient:		Date of Birth:	
Last First Mi		Social Security #:	
Address:		Employed:	YES or NO
		Where employed:	
City State Zip		Work phone #:	
Phone:		E-Mail Address:	
Home # Cell #		**Drug Allergies:**	
Language preference:		Allergic reaction:	

Are you a veteran? YES or NO	Emergency contact information
Have you applied for Medicaid? YES or NO	Name:
If yes, what month & year? /	Phone #:
Are you enrolled in Medicare? YES or NO	Relationship:

Marital Status	Sex	Race	Homeless Status	Medical Insurance
___ Married	___ Female	___ White	___ Not Homeless	___ No Insurance
___ Single	___ Male	___ Black	___ Shelter	___ Medicare: A B D
___ Widowed		___ Asian	___ Street	___ Medicaid
___ Divorced		___ Hispanic	___ Living with friend	___ Veterans
___ Separated		___ Indian	or relative	___ Private Ins
		___ Other		___ Carrier Name

Are you disabled? YES or NO If yes, When? By whom?

Do you have a regular doctor? YES or NO	Have you been to an ER in the past year? YES or NO
If yes, Who?	If yes, Name of hospital or ER:
Date of last visit:	If yes, number of visits to the ER:
Number of people in household:	In an emergency, which hospital would you use?

List full name & age of all household members — Circle type of income

Name	Age	Wages	Soc. Sec/ Disability	Retirement	Workers comp/ Unemployment	Food stamps Alimony Child support	Total
		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
Total household income		$	$	$	$	$	$

Patient Agreement/Disclosure

I agree to allow Beckley Health Right, Inc to complete any patient assistance program enrollment processes on my behalf, which may include disclosure of personal & medical information, soft credit check and other information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. Your information is confidential and secure, and only available to licensed prescribers, Beckley Health Right pharmacy and Administrative staff. By signing this form, I attest that this information is true and accurate. I also agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) or if my financial situation changes that I will immediately notify Beckley Health Right, Inc. I also agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

Signature Date

CLINIC USE ONLY

Form complete	Initials		Tax return	Initials	
Photo ID	Initials		HIPAA Form	Initials	
POI	Initials		0 Income form	Initials	

BECKLEY HEALTH RIGHT

"BECAUSE WE CARE"

2025

CONSENT FOR TREATMENT

PATIENT NAME DATE OF BIRTH

GENERAL CONSENT FOR TREATMENT

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure.

RELEASE OF MEDICAL INFORMATION

This form has been fully explained to me. and I understand it's content and significance. I consent to Beckley Health Right, Inc. to use my health information related to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of Beckley Health Right, Inc. or other treating providers all as permitted under federal and state law and regulations.

Signature of Patient **Date**

Signature of Legal representative(if patient is unable to sign) **Relationship to patient**

BECKLEY
Health Right, Inc.
BECAUSE WE CARE

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will be part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Beckley Health Right, Inc. to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient Name:_____ DOB:_____

Patient Signature:_____Date:_____

Patient Intake Questionnaire 2025

Name:
Date of Birth:

Personal Habits: Do you have any of the following habits?				
Yes	No	Smoke Tobacco? If yes, how many packs per day?		Age Started?
Yes	No	Chew Tobacco? If yes, what type?	How much?	Desire to quit?
Yes	No	Body Piercing? If yes, where?	How many?	
Yes	No	Have Tattoos? If yes, where?	Who put them on?	Friend or Professional
Yes	No	"Shot up" drugs? If yes, when was the last time?		Which drug?
Yes	No	Used other drugs? If yes, when was the last time:		Which drug?
Yes	No	Drink Alcohol? If yes, how much?		How often?
Yes	No	Told you could NOT give blood or plasma? If yes, when?		Why?

Your Medical History: I have problems with my health in the following ways. (check all that apply)					
	Anxiety		Depression		Drug Dependence
	High Blood Pressure		Heart Attack		Blood Clots
	Asthma		Epilepsy or seiqures		Emphysema/COPD
	Pneumonia		Migraines		Hepatitis (sore liver)
	Stomach/Heartburn		Rectal Bleeding		Diabetes (type)
	Cancer (Where)		Bone Problems		Skin Infections
	Gum/Tooth decay		Eye Problems		Hearing Problems
	Sexual Problems		Bladder Infections		Kidney Stones/Infections
	Breast Lump		Testicular Lump		Blood Transfusions (year)
	Pain		Thyroid		Other:

WOMEN ONLY:						
Could you be Pregnant?	yes	no		Are you Menopausal?	yes	no
Do you use Birth Control	yes	no	what type?	Do you self breast exam?	yes	no
Date of last Pap test?				Date of last Mammogram?		
Date your last menstrual cycle started?				How many pregnancies?		
Number of live births?		Vaginal Birth:	Y or N	C-Section:	Y or N	

FAMILY HISTORY: (who in your family has had the following health problem? (check all that apply) Specify Family Member-M=mother, F=father, GM=grandmother, GF=grandfather			
Substance Abuse?		Kidney problems?	
Alcohol/Drugs?		Asthma?	
Cancer? (what type)		Migraines?	
Diabetes?		Depression/Nerves?	
Heart Problems?		Seizures/Fits?	
Heart Attack?		Thyroid Disease?	
High Blood Pressure?		Bleeding Disease?	

Patient Intake Questionnaire 2025 (continued)

Name:			
Date of Birth:			
Prescription Medication you are currently taking			
Drug Name	Dosage	How Often Taken	Last Time Taken

PREFERRED PHARMACY:	

Over the Counter Medications and Home Remedies Currently Used			
Medicine Name	Dosage	How Ofter Taken	Last Time Taken

Hospitalizations and Surgery:	
Date	Reason

Recent Radiology Tests/Labs (within last 6 months)	
Date	Reason

If you have any other concerns that you think might impact your care at Beckley Health Right, please add them here:

I give my permission to be examined and treated by Beckley Health Right providers and agree to do my part to follow the medical plan recommended to me by the Beckley Health Right Staff.

Patient Signature: Date:

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2021

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

The terms of this Notice of Privacy Practices ("Notice") apply to Beckley Health Right Inc., its affiliates and its employees. Beckley Health Right Inc. will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Beckley Health Right, Inc. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;

- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;

- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Beckley Health Right, Inc. in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.