

# **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  
2026 PATIENT REGISTRATION FORM**

<b>Patient:</b>	Date of Birth:	
Last                      First                      Mi	Social Security #:	
<b>Address:</b>	Employed:	YES or NO
_____	Where employed:	
City                      State                      Zip	Work phone #:	
<b>Phone:</b>	E-Mail Address:	
Home #                      Cell #	Drug Allergies:	
<b>Language preference:</b>	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
<input type="checkbox"/> Married	<input type="checkbox"/> Female	<input type="checkbox"/> White	<input type="checkbox"/> Not Homeless	<input type="checkbox"/> No Insurance
<input type="checkbox"/> Single	<input type="checkbox"/> Male	<input type="checkbox"/> Black	<input type="checkbox"/> Shelter	<input type="checkbox"/> Medicare:    A    B    D
<input type="checkbox"/> Widowed		<input type="checkbox"/> Asian	<input type="checkbox"/> Street	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Divorced		<input type="checkbox"/> Hispanic	<input type="checkbox"/> Living with friend	<input type="checkbox"/> Veterans
<input type="checkbox"/> Separated		<input type="checkbox"/> Indian	<input type="checkbox"/> or relative	<input type="checkbox"/> Private Ins
		<input type="checkbox"/> Other		<input type="checkbox"/> 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
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
<b>Total household income</b>		\$	\$	\$	\$	\$	\$

**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"

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PATIENT NAME

DATE OF BIRTH

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HAVE YOU LOST INSURANCE IN THE LAST 12 MONTHS?

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IF SO, WHAT PROMPTED THE LOSS?

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WHO WAS YOUR INSURANCE CARRIER?

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CONSENT FOR TREATMENT  
2026

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.

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Signature of Patient

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Date

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

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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 2026

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 seizures	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?





# BECKLEY Health Right, Inc.

BECAUSE WE CARE

## 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;