Family Health Care and Wellness Center

NEW PATIENT REGISTRATION

Patient Demographic:

First Name:	MI:	Last Name:	Date of Birth:
SS#:	Marital Status:	Ethnicity/Language:	Sex:
Address:	City:	State:	Zip:
Cell Phone:	Home Phone:	Email:	
Emergency Contact:	Phone:	Relationship:	

Insurance Information:

Insurance Policy Name:	Member ID:	Insurance Holder's SSN:
	Group Number:	Insurance Holder's DOB:
Insurance Policy Holder:	Relationship to Patient: Self__ Spouse__ Child__ Other__	Work Status: Employed ____ Unemployed ____ Retired ____ Student ____
	Gender: Male Female	

Assignment of Insurance Benefits:

I hereby authorize direct payment of medical benefits to Family Health Care and Wellness Center for services rendered. I also understand that I am financially responsible for any payment and/or balance not covered by my insurance.

I hereby authorize any information about me to be released to my health insurance carrier and its agents, including any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Family Health Care and Wellness Center to release any medical records that may be necessary for medical care or the processing of applications for financial benefits.

Acknowledgement of Review of Notice of Privacy Practices:

These are your rights regarding health information about you. Even though your health record is the property of the Facility, the information belongs to you. You have the following right regarding your health information:

I _____ understand, agree, and consent to medical evaluations, treatments, Privacy Practices, Release of billing information, Medication History and Authority, and Assignment of Benefits at Family Healthcare and Wellness Center. I also consent to take full responsibility for any amount not covered by the insurance company.

_____ _____

Patient's Printed Name: Date:

_____

Patients Signature:

_____ _____

Other Authorized Person's Relationship to Patient

Family Health Care and Wellness Center

NEW PATIENT REGISTRATION

Family Medicine Medical History Questionnaire:

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. All information given will be kept strictly confidential.

Main reason for today's visit: _____

Other questions/concerns: _____

Medical History:

Please check all that apply:

- ☐ Cancer _____
- ☐ High Blood Pressure _____
- ☐ Thyroid Disorder _____
- ☐ Heart Disease _____
- ☐ Asthma/Lung Problems _____
- ☐ Anxiety/Depression _____
- ☐ Other: _____

Family Medical History:

Please specify mother, father, sibling, or other:

- ☐ Cancer _____
- ☐ High Blood Pressure _____
- ☐ Thyroid Disorder _____
- ☐ Heart Disease _____
- ☐ Asthma/Lung Problems _____
- ☐ Anxiety/Depression _____
- ☐ Other: _____

Drug/Food Allergies: _____

Surgeries/Hospitalizations: _____

Preferred Pharmacy: _____ Phone #: _____

Social History:

Tobacco: Yes / No ☐ Cigarettes	**Alcohol:** Yes / No If yes, how often _____ drinks a day _____ drinks a week	**Caffeine**: Yes / No Drinks per day _____ ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks
Recreational Drugs: Yes / No If yes, list type:		

Medications:

Please list all medications you are taking, including both prescription and non-prescription.

Drug Name:	Strength:	Quantity:	Times Per Day:	Reason:	Start Date:

Patient Authorization/Release of Information:

Date Authorized	Name	Relationship	Phone Number	Patient Initials

- I understand I may rescind all or some of the above authorization(s); however, to implement the change, I must personally visit the clinic, provide the above-requested information, and enter my initials.

- I authorize Family Healthcare and Wellness Center to release my protected health information to other healthcare providers, healthcare payers, government agencies and other healthcare organizations as reasonably necessary for continuity of care, reimbursement, audit and/or quality of care-related purposes**.**

_____

Patient's Printed Name

_____

Patients Signature:

_____

Today's Date

No-Show, Late & Cancellation Policy:
Descriptions:

"No-Show" is defined when any patient fails to arrive for their scheduled appointment.
"Same Day Cancellation" is defined when any patient cancels an appointment less than 24 hours before their scheduled appointment.
"Late Arrival" is defined when any patient who arrives for their appointment 15 minutes after the expected arrival time for the scheduled appointment.

Policy:

Effective immediately, it is the policy of Family Health Care and Wellness Center to monitor and manage appointment no-shows and late cancellations. Our goal is to make **your health our mission**, and to do this the patient must show up for all appointments. If it is necessary to cancel an appointment, patients **are required** to call or leave a message at at least 24 hours before their appointment time. This will help our office utilize appointments for our patients and to be respectful of our provider's and staff's time. The impact of no-showing appointments not only jeopardizes the health of the no-showing patient, but it is also unfair to patients who might have needed that appointment slot.

New patients:

It is **mandatory** for new patients to show up for their first initial appointment unless there is a medical or family emergency.

- New Patients should arrive about 30 minutes before their appointment time for new patient paperwork completion purposes.
- In the event a patient misses their new patient appointment, the office will attempt to contact the patient, notifying them of the offices no-show policy, and attempt to get them rescheduled, where they will be given our "no-show policy." If the second appointment is followed by another no-show, the patient will be dismissed from our care. If a patient is dismissed, a letter of dismissal will be mailed to not only the patient, but to their insurance company stating why the patient was dismissed from our care.

Established patients:

Established patients- in the event a patient has 3 or more no shows, the patient will lose privileges of being able to call ahead to make appointments. Instead, the patient will only be able to make appointments via walk-in or cancellation call-back request **IF** any appointments become available.

*** Our office spends much time the day before your appointment to prepare for your visit ***
*** Please be respectful of our time ***

My signature indicates that I have read and understand the No-Show, Late & Cancellation Policy.

_____ _____

Patient Printed Name **Patient or Guardian Signature**

_____

Date

Family Health Care and Wellness Center

NEW PATIENT REGISTRATION

AUTHORZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

GENERAL CONSENT FOR MEDICAL TREATMENT:

As a patient of **Family Health Care and Wellness Center**, I understand that the clinic has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment if all patients. I hereby authorize the clinic, and its affiliated physicians and other licensed providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries or other conditions. I understand that the providers will act in good faith and provide quality care and treatment. However, a specific cure or resolution cannot be promised. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment. Additionally informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

REASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE:

I authorize the clinic to bill my insurance company or other designated third-party payer for the services provided related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payments, and non-covered services. I/we agree to pay the established care rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies for financial counseling and assistance.

RELEASE OF MEDICAL INFORMATION FOR TPO AND EMERGENCY CARE:

I do hereby authorize **Family Health Care and Wellness Center** to release medical or other information to any insurance company or third-party for which reassignment of my benefits has been made for a medical service. I understand that my information may be released by law for any business activity related to the treatment, payment and operation (TPO) related to my care. I also authorize the health care providers of the clinic to release medical and other information to other healthcare providers or facilities as needed for emergency treatment, payment and operation (TPO) related to my care. I also authorize the health care providers of the clinic to release medical and other information may also be released to immediate family members who are actively engaged in the management of my care. In all other cases, I understand that I will be required to authorize the release of protected health information (PHI) for any other reason.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:

By signing this form, I acknowledge the receipt of the notice of privacy practices of the clinic. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this notice. If you have any questions about our notice of privacy practices, please contact us on the above telephone number.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS. THIS AUTHORIZATION/ACKNOWLEDGEMENT REMAINS IN FORCE UNTIL SUCH A DATE THAT IT IS REVOKED OR REPLACED.

Patient Name: _____ DOB: _____

Patient Signature: _____

Parent/Guardian Signature: _____ Date: _____

Relationship of Signer to the patient: _____