Wellington Regional Primary Care

Dear Valued Patient,

Thank you for choosing Wellington Regional Primary Care, where we strive to offer the best possible medical care. It is our pleasure to welcome you as a patient. This letter is designed to provide you with some important information about our services and office operation.

EMERGENCIES/AFTER HOURS: If the office is closed and you have a medical emergency, please dial 911 or proceed to the closet emergency room. For non-life-threatening emergencies, you may leave a message with our answering service or on our voicemail and we will return your call the next business day. Prescription refills will NOT be handled after hours, please call during normal business hours. Please refer to our prescription refill policy below.

PRESCRIPTION REFILLS: Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy and your provider to receive and respond to your request before you run out of your medication. For maintenance medications, your healthcare indication of the need to schedule a follow appointment with your provider. ******We do NOT manage chronic pain for long term, as chronic pain patients should be cared for by pain management specialists. ******

ONLINE HEALTH RECORDS (PATIENT PORTAL): Provide your email address and automatically receive an invite to gain access to your records online. You will receive an invitation from IQ Health, where you will complete the enrollment process. You will gain secure online access to your healthcare records, including but not limited to allergies, immunizations, medications and completed procedures, health problems… etc. This application is free of charge and available with internet connectivity, 24 hours a day, 7 days a week.

YOUR OPINION MATTERS: After your visit, you may receive an email from our survey partner, MedicalGPS, LLC. PLEASE take a moment to let us know how we are doing. If someone stood out during our visit, please drop his or her name in the comments, as we would love to know.

PAYMENT/BILLING QUESITONS: Payment will be required at the time of the services are rendered. We will collect all outstanding balances within WRPC and for services performed at the time of service. Please note that your insurance company may process the claim with high patient responsibility. You may receive a statement from Wellington Regional Primary Care for any balance billing. Method of payment includes Cash, Check, MasterCard, Visa, Discover, and American Express. If you have a question regarding your statement, you may contact the office directly or our billing office at 888-804-6274.

FORMS: Some forms are extensive and will require a fee of $25 at the time of request. There are forms that may require an appointment prior to completion of the requested documents.

IDENTIFICATION: The protection of your identity is important to us. You will be required to produce a government issued photo identification card, along with your insurance card(s) at every visit.

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (check)	Date of Birth	Marital Status (check)	Primary Care Physician
☐ M ☐ F		☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other: _____	

Preferred Language (check)	Race (check)	Ethnicity (check)
☐ English ☐ Spanish _____	☐ Asian ☐ Black ☐ White ☐ Other: _____	☐ Hispanic ☐ Not Hispanic ☐ Unknown

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: ☐ Patient

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Responsible Party?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: ☐ Responsible Party

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: ☐ Responsible Party ☐ Emergency Contact

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Guardian?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: ☐ **Self Pay**

Check if same as: ☐ Responsible Party			Check if same as: ☐ Responsible Party		
Subscriber / Member Name	Date of Birth		Subscriber / Member Name	Date of Birth	
What is Patient's Relationship to Subscriber?	Gender (check) ☐ M ☐ F		What is Patient's Relationship to Subscriber?	Gender (check) ☐ M ☐ F	
Primary Insurance Company	Begin Date		Secondary Insurance Company	Begin Date	
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature **Date**

Patient/Legal Guardian Print

NOTICE of PRIVACY PRACTICES

A copy of Wellington Center of Internal Medicine's HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HALTH INFORMATION and EMERGENCY CONTACT

I authorize Wellington Center of Internal Medicine to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Wellington Center of Internal Medicine to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell number. YES _____ NO _____

Emergency Contact: _____ Phone Number: _____

Email Address: _____ Relationship: _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Wellington Center of Internal Medicine strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. Wellington Center of Internal Medicine will submit clams to my primary and secondary insurance directly for their services. I authorize payment directly to Wellington Center of Internal Medicine of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize Wellington Center of Internal Medicine to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize Wellington Center of Internal Medicine to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Wellington Center of Internal Medicine. Any photographs or other images taken will become part of my medical record. Wellington Center of Internal Medicine will not use such photographs or images for any other purpose s without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Wellington Center of Internal Medicine will provide me with information and forms prior to such procedures. I grant Wellington Center of Internal Medicine consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize Wellington Center of Internal Medicine to search for and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying Wellington Center of Internal Medicine. I understand that Wellington Regional Center for Internal Medicine is a teaching facility and has affiliations with a variety of healthcare related educational programs such as Pharmacy schools and Medical schools. I consent to having Residents and Pharmacy students participate in my care under the supervision of their attending physicians.

_____ _____

Patient's Name (Please Print) Signature

_____ _____

Patient Representative (If patient is unable to sign) Signature

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATIO

Patient Name: _____Date of Birth: _____
Maiden/Prior Names: _____Current Phone#: _____
Current Address _____

I am requesting disclosure of my Protected Health Information for the following purpose:

_____ Continuing Care _____ Disability Determination
_____ Legal Investigation _____ Other: _____

I authorize the release of the following:

_____ Provider office notes
_____ Lab results
_____ Diagnostic Reports
_____ Other: _____

Items below will not be included unless checked:
_____ Psychological Evaluation
_____ Alcohol and Drug Abuse Treatment Records
_____ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

_____ _____ _____
Facility/Provider's Name Phone or Fax Number Address City, State, Zip code

This authorization will expire on ___/___/20__. (If not indicated, authorization will expire one year from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practice. The revocation will not apply to information that has already been released in response to their authorization. Once the above information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness Signature Date Signed

This authorization is intended to allow Wellington Center of Internal Medicine to release information, both written and verbal, for the specific purpose and like of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosures. Wellington Center of Internal Medicine is not liable for such re-disclosures.

Wellington Regional Primary Care

Patient No Show Policy

Thank you for choosing our practice for your healthcare needs. To keep our schedule available for new and established patients, please see our No-Show policy.

If you are unable to attend your scheduled appointment, Wellington Regional Primary Care Requires advanced notification at least 24 hours prior to scheduled appointment for cancelation.

Any missed visit without notice will be considered a NO SHOW.

A patient who fails to present for his or her scheduled appointment more than three times without the requested advance notification will be discharged/terminated from the practice.

_____ _____

Signature **Date**

Wellington Regional Primary Care

Name:_____ DOB: _____

Reason for visit: _____

Preferred Pharmacy (Name/Location):_____

DO YOU HAVE ANY ALLERGIES: _____

List of Medications **CURRENTLY** taking (prescribed, over the counter and vitamins):

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often:

_____ If you have additional medications please list on back of form.

Medical History (mark ALL that apply):

- ☐ ADD
- ☐ ADHD
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bladder Cancer
- ☐ Bowel Problems
- ☐ Breast Cancer
- ☐ Breathing Difficulties
- ☐ Cancer (type): _____
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Lung Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pancreatic Cancer
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polymyalgia
- ☐ Prostate Cancer
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Sjogren Syndrome
- ☐ Stroke / CVA
- ☐ Other: _____

_____

_____

Surgical / Procedures (mark ALL that apply):

- ☐ ACL Surgery / Reconstruction
- ☐ Adenoids removed
- ☐ Appendix removal
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Cardiac Bypass Surgery
- ☐ Cardiac Catheterization
- ☐ Cataract Surgery
- ☐ Colon resection
- ☐ Colostomy / Reversal
- ☐ C-Section
- ☐ D&C (Dilation & Curettage)
- ☐ Defibrillator Implant

Name:_____ DOB: _____

- ☐ Gallbladder removal
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Splenectomy
- ☐ Tonsils removed
- ☐ Total Joint replacement
- ☐ Lumpectomy
- ☐ Lymph node biopsy
- ☐ Mastectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Pacemaker
- ☐ PTCA (Angioplasty)
- ☐ Shoulder Surgery
- ☐ Other not listed:

_____

_____

Women's Health:

	Date	Results	
Last menstrual period	_____	☐ Normal	☐ Abnormal
Pap / Pelvic Exam	_____	☐ Normal	☐ Abnormal
Last Mammogram	_____	☐ Normal	☐ Abnormal
Bone Density	_____	☐ Normal	☐ Abnormal

Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Abortions: _____

Health Maintenance:

	Date	Results	
Physical Exam/Wellness Visit	_____	☐ Normal	☐ Abnormal
Cholesterol	_____	☐ Normal	☐ Abnormal
Colonoscopy	_____	☐ Normal	☐ Abnormal
EGD	_____	☐ Normal	☐ Abnormal
Prostate / PSA	_____	☐ Normal	☐ Abnormal
Stress Test / Nuclear Stress Test	_____	☐ Normal	☐ Abnormal

Immunizations:

	Month / Year		
Hepatitis A	#1_____	#2 _____	
Hepatitis B	#1_____	#2_____	#3 _____
Gardasil (HPV)	#1_____	#2_____	#3 _____
Influenza	_____	Pneumonia	_____
Tetanus	_____	Zostavax (Shingles)	_____
TB Skin Test	_____	Chicken Pox	_____

Social History:

Smoker: ☐ Never ☐ Formerly ☐ Currently

If YES, mark ALL that apply: ☐ Cigarettes ☐ Cigars ☐ Chewing/Dipping Tobacco ☐ Electronic Cigarettes

How much per day:_____ How many years:_____ Quit Date: _____

Name:_____ DOB: _____

Alcohol use: ☐ Never ☐ Daily ☐ Social Estimated daily consumption: _____

Are you sexually active? ☐ Yes ☐ No
Are you using a form of birth control? ☐ Yes ☐ No If yes, type: _____

Have you ever had a STD? ☐ Yes ☐ No If yes, type: _____

Street drug use: ☐ Never ☐ Previous ☐ Currently Type of Drug(s): _____
Do you feel safe at home? ☐ Yes ☐ No

Living Will / POA: Do you have a living will? ☐ Yes ☐ No
Do you have Durable Power of Attorney for healthcare? ☐ Yes ☐ No

Family History: ☐ Adopted ☐ Unknown

Mother Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Father Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

(Please list any serious medical history that runs in your family)

Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent

Provider List: (Physician/Practice Name)

Cardiologist:_____ Gastroenterologist:_____

General Surgeon: _____ Neurologist_____

OBGYN: _____ Urologist: _____

Other: _____

Hospital Admission(s) / ER Visit(s): Year Diagnosis

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____