We Care Clinic

Patient Registration Form

Patient Information

Name_____ SS#_____

LAST FIRST MIDDLE

DOB _____ Sex _____ Race _____ Marital Status _____

Language _____ Email _____

Address _____

STREET CITY STATE ZIP CODE

Ph. #1 _____ Ph. #2 _____ Ph. #3 _____

How did you hear about us?_____

Employer

Employment ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self Employed ❑ Retired

Company Name_____

Address _____

STREET CITY STATE ZIP CODE

Phone Number _____Occupation_____

Emergency Contact

Emergency Contact Name

_____

Relationship to Patient_____ Phone Number_____

Insurance Information

Insurance Name _____ Group Name _____

ID Number _____ Policy Holder Name _____

Social Security # _____ DOB _____

I attest that all of the above information is correct and acknowledge that it is my responsibility to let We Care Clinic know as soon as possible if any of my information changes.

_____ _____

Patient Signature Date

We Care Clinic

Office Policies

Change of demographics or Insurance Policy

If you change your insurance policy, please let us know as soon as possible so we can verify your benefits correctly. Please present your current health insurance card at each office visit. The same applies to your personal demographics. There is no way for us to know you have moved or changed phone numbers, so please let us know as soon as possible so we can update our system.

Annual Wellness Visit (AWV) is required

The AWV is a preventive annual wellness visit, not a "routine physical checkup" that adults receive yearly from their physician or other qualified non-physician practitioner. The annual wellness visit generally doesn't include a physical exam. Your doctor or other health care provider will ask you to fill out a "Health Risk Assessment" questionnaire as part of this visit. Answering these questions can help you and your doctor develop a personalized prevention plan to help you stay healthy and get the most out of your visit. Your visit may include, depending on your age:

- Keeping track of your height, weight, blood pressure, and other regular measurements
- A risk assessment for health (questions you answer about your health)
- An examination of your medical and family history
- Creating or updating a list of your current healthcare providers and prescriptions
- Examine for signs of memory loss or dementia, as well as depression, anxiety, and stress.
- Discussion of your risk factors and potential lifestyle changes or treatment options
- A schedule for screening for appropriate preventive services (as needed)
- Vaccinations

Every patient is required to complete their annual wellness visit; failing to do so may result in discharge from our practice.

Chronic medical conditions require follow-up

Chronic medical conditions such as diabetes, hypertension, depression, and anxiety require frequent follow-ups to ensure the best care possible. Once patients with chronic medical conditions are stable on their medication, they need a follow-up every 3 months. Once stable, patients with other chronic medical conditions need a follow-up every 3-6 months, depending on their care plan. Medications may not be refilled unless patients keep their follow-up appointments.

Urgent Care Center, ER, or Hospital Stay

Please contact our office after you are discharged to update us on your condition and the place where you were evaluated so we can obtain records and schedule a follow-up visit. Per medicare standards, you must be seen within 7 days of discharge.

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Wellmed Medicare Patients

Some insurance plans such as Cigna, United Healthcare, Wellpoint, and Humana that fall under Wellmed management require their patients to take preventative measures such as mammograms, colonoscopies, diabetic eye exams, and other preventative exams. They also require you to pick up your medications, or you will agree to have your medications delivered to your house. I understand that if I fall under what they classify as band 4 or band 5 patients, I must be seen every month. **Failure to keep up with your preventative measures may result in being discharged from our practice.**

Medication Refill Policy

It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. Medication refills will only be addressed during regular office hours (Monday – Friday, 8:00 am – 5:00 pm). Please notify the office the next business day if you are out of medication after hours. No prescriptions will be refilled on Saturday or Sunday. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Medications and Vitamins

Patients must bring their medications and vitamins to all visits in original bottles. Not only do insurance plans require us to review your medications, it is also for your safety. There is no universal health system where we can see what medications other providers have prescribed to you. For this reason, it is important that you bring your medications so we can see that there are no adverse interactions with your medications. Also, it helps us make sure you are not taking double doses of the same medications. We have seen patients, when they bring their medications, that they do not realize they are taking the same medications twice.

Authorization to Release Information (PHI)

I hereby authorize We Care Clinic to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until I revoke it in writing.

Text Contact Consent

I authorize We Care Clinic to contact me via text message to better serve my needs. Our platform, Weave, can be used to send HIPPA-compliant messages.

We Care Clinic

Late arrivals, cancellations, and no-shows

- Please arrive 10 minutes before your appointment to allow for check-in and any paperwork.
- We ask for 48-hour notice to cancel or reschedule
- Patients arriving 15 minutes or more past their scheduled appointment time may be
- rescheduled.
- Failure to give proper notice for cancellations or rescheduling may result in:
    - $25 missed appointment fee
- Patients with three (3) no-shows in 1 year may be considered for dismissal from the practice.

Acknowledgement of receipt of notice of privacy practice

I acknowledge receiving and reading a copy of We Care Clinic's "Notice of Privacy Practices." The notice describes how We Care Clinic may use and disclose my protected health information (PHI), the restrictions on the use and disclosure of my healthcare information, and my rights regarding my PHI.

I acknowledge that I have read, understand, and agree to the policies outlined in this document.

Printed name:_____

Signature:_____ Date:_____

We Care Clinic

Financial Policy

Billing your insurance

- Please present your current health insurance card at each office visit.
- If you have no insurance, then payment in full is required at the time of service.
- **Co-pays, co-insurance, and deductibles must be paid at the time of service.**
- I understand and agree it is my responsibility and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical services I receive.
- I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company plan. If I have requested a PCP change that my insurance company does not process, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
- I understand and agree it is my responsibility and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical services I receive.

Insurance coverage of Annual Wellness versus Problem-oriented visits

Annual wellness visits may reveal problem-oriented issues that require evaluation and management (for example, sick visits, diabetes, hypertension). To comply with insurance company billing policies, this then prompts charges for both categories. While annual wellness visit services may not require a co-pay or deductible, problem-oriented services do. If you need further explanation about incurring additional fees for services provided during your visit, please speak with our billing team.

Returned checks

The charge for a returned check is $35. You must pay in full for the check amount and the returned check fee within 10 days.

Forms

If you need forms to be filled out by the provider, some forms may require a fee upon returning the signed forms to you.

I acknowledge that I have read, understand, and agree to the policies outlined in this document.

Printed name:_____

Signature:_____ Date:_____

We Care Clinic

Consent & Direction for Release of Protected Health Information (PHI)

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) and to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at any time. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law, as is described in the Notice of Privacy Protection statement, which you have read and signed. Regarding the release of your health information, please read through the listed below and check the box that reflects your wishes.

Please circle your response to the following:

May we leave messages on a voicemail at home or on your cell phone to discuss appointments or treatments? Yes No N/A

May we discuss your appointments/treatment with your spouse? Yes No N/A

During Examination

We Care Clinic may speak with all persons accompanying me during my examination directly and/ or allow them to hear all information or discussion indirectly. I understand that if I don't want that person privy to the conversation, I must ask that person to leave the exam room.

Yes No N/A

Telephone Contacts

I consent to receive all information regarding appointments, laboratory, radiology, and other testing results, as well as financial information, including reminders for outstanding bills on my home telephone and/or personal cellular phone.

Yes No N/A

Patient Signature: _____Date: _____