Wellness Family Medicine

Patient Information

Name: _____ SS#: _____
(First) (MI) (Last)

Mailing Address _____
(Street or PO Box) (City) (State) (ZIP)

Date of Birth: _____ Age: ___ Marital Status: _____

Race: ____ Ethnicity: _____ Sex:__ Language: _____
English/Spanish/French/Other

Home Telephone: _____ Business:( )_____

Cellphone: _____ Email: _____

Employer:_____ Address:_____

Spouse/Parent's Name: _____

Spouse/Parent's Employer: _____

Are you, the patient, covered by spouse or parent's insurance? _____

Spouse/Parent's DOB: _____ Spouse/Parent's SS#_____

EMERGENCY CONTACT PERSON:

_____
(Name) (Phone) (Relationship)

LONG TERM INSURANCE AUTHORIZATION:
I request payment of authorized benefits be made on my behalf to Wellness Family Medicine for any healthcare services rendered to me by this facility.
I authorize any holder of medical information about me to release to health care financing administration and/or my other insurance companies any information to determine benefits payable. I understand that I am responsible for any amounts approved but not covered by my insurance.

SIGNATURE:_____DATE:_____

NOTICE OF PRIVACY PRACTICES

Please read and sign

Patient Health Information

Under federal law. your patient health information is protected and confidential. Patient health information includes information about your symptoms. test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How we use your patient health information.

We use health information about you for treatment, to obtain payment for administrative purposes, for evaluation of the quality of care, and so forth.. Under some circumstances we may be required to use or disclose information even without your consent.

Treatment: We will use and disclose your health information to provide you with medical treatment and services. We may also disclose the information to other health care providers who are participating in your treatment to pharmacists who are filling your prescriptions, to laboratories performing tests and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to perform various routine functions. (e.g. quality evaluations or records analysis.)

We may use your information to contact you. We may also contact you to provide information about referrals for follow-up with lab results to inquire about your health or other reasons.

Special Situations: We may be required by law to report gunshot wounds, suspected abuse or neglect and so on. We may be required to disclose vital statistics, diseases and other similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials.

We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke authorization.

Individual Rights: you have certain rights with regard to your health information, for example: You may request restrictions on certain uses and disclosures of your health information, though we are not required to agree to such restrictions.

You may ask to communicate with us confidentially, for example, sending notices to a special address.

In most cases. you have the right to get a copy of your health information. There may be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information. You may request list of instances where we have disclosed health information about you for reasons other than treatment, payment or operation. There may be a charge for this information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices, regarding health information and to abide by the terms of the Notice currently in effect.

We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies: we will change our Notice and post the new Notice in the patient reception areas. You may also request a copy of our Notice at any time.

If you are concerned about your privacy rights. or if you disagree with a decision we made about your records. you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person: If you have any questions, requests, or complaints, please contact:

WELLNESS FAMILY MEDICINE
Attn: Jayne Martin, Practice Manager
1241 Boiling Springs Rd.
Spartanburg, SC 29303
(864) 591-0992
jmartin@wellnessfamilymedicine.com

HIPPA South Carolina
US DHHS
Atlanta Federal Center
Suite 3870
61 Forsyth Street
Atlanta, GA 30303-8909

____I understand that a patient's health information is private and confidential. I understand that Wellness Family Medicine has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Wellness Family Medicine by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices.

____This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of another patient's private health matters, I will not disclose them to others and will treat any such knowledge as strictly confidential and private.

____My signature verifies that I understand how Wellness Family Medicine may use patient information and I have read the "Notice of Privacy Practices" and I agree to be seen and treated under stipulations as described.

Patient's Names | Date of Birth | Today's Date

Wellness Family Medicine: New Patient Intake Form

Legal Name: _____ DOB: _____ Date: _____

MEDICAL HISTORY Please check all that apply: *Pulmonary* o Emphysema o Pneumonia o Bronchitis o Asthma

Cardiovascular o Stroke o High Blood Pressure o Elevated Cholesterol o heart attack o stroke

Endocrine: Diabetes If yes, how long _____ and how much did you weigh at diagnosis_____

GI: o Hepatitis A or B o Hepatitis C o Cirrhosis o Gallbladder Disease o Ulcers o surgery _____

GU: o Frequent urination/Bladder Infections o Sexually Transmitted Infections o Prostate Trouble

Orhtopedic: o Arthritis o Osteoporosis o Fractures o Low back pain o Surgeries _____

Neuro/Psych o Migraines o Depression o Anxiety or Panic Disorder o Post-traumatic Stress Disorder o Alcohol or Substance Use Problem o Other: _____

SYSTEMS REVIEW *General:* o Recent: weight loss o weight gain o Fatigue o Fever o Night sweats

Skin: o Rashes o Lumps o Itching o Dryness o Color changes o Hair and Nail changes o skin cancer

Head: o Headaches o Head Injuries o Dizziness

Eyes: Date of Last Eye Exam: _____ o Eye pain o Double vision o Glaucoma o Cataracts o

ENT: o Frequent Colds o Nasal stuffiness o Hay fever o Nosebleeds o Sinus trouble o Allergies: dust/animal/seasonal
Ears: o Hearing loss o Ear pain o Ringing in the ear Mouth and Throat:

Heart: o chest pain o rhythm problems o abnormal heart valve: o High blood pressure o poor circulation

Respiratory: o chronic cough o shortness of breath o wheezing

GI: o change in bowel movements o blood per rectum o nausea o vomiting

Urinary: o frequent bladder infections o nighttime urination o incontinence

Ortho: o arthritis o joint pain requiring medicine o calf pain with walking

Neuro: o TIA or stroke in past o memory loss o recent numbness or weakness o history of seizure

Heme/Lymph: o bleeding tendencies/bruising o history of anemia o fluid accumulation in arms/legs

Breasts: o pain o discharge o other changes or abnormalities.

Smoking: o yes. O no If yes, how many packs per day _____. How many years _____

Alcohol: o yes o no. If yes, how many drinks/wk _____ preferred type of alcohol _____

Family History: What medical problems do/did your mother and father have?

Medications: Please list Rx and over the counter meds on back of this form. Include writing MD/NP

WELLNESS FAMILY MEDICINE/UPSTATE OCC MED

Date : _____

Name: _____

Please list below any medications, including over-the counter, that you have taken in the past 30 days. If prescription, please list the physician who prescribed it to you and for what reason you are taking the medication.

Medication	Reason for taking	Physician

MEDICATION ALLERGIES

_____

_____

_____

_____

Signature: _____ Date:_____

WELLNESS FAMILY MEDICINE

Request for authorization for disclosure of Protected Health Information to family member(s), friend(s) or caregiver(s)

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Signature:_____

Patient DOB:_____

Mother's Maiden Name:_____

If the person(s) authorized above call for access to your HPI, they will have to give the above identifiers in order to have access to the information over the phone. This includes billing information. Picture ID will be requested if requesting access in person.

WELLNESS FAMILY MEDICINE
1241 BOILING SPRINGS RD.
SPARTANBURG, SC 29303
Fax: 864-591-0776

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol abuse and drug abuse.

The information you may release subject to this signed release form is as follows:

- o Complete Records
- o Care Plan
- o Pathology Reports
- o Mental Health Records
- o Hospital Reports
- o History & Physical
- o Lab Reports
- o Treatment Record
- o Medication Record
- o HIV/AIDS Reports
- o Progress Notes
- o Radiology Reports
- o Operative Reports
- o Drug/Alcohol Abuse Reports
- o Other (Please specify)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Wellness Family Medicine/Upstate Occ Med
1241 Boiling Springs Rd.
Spartanburg, SC 29303
Fax: 864-591-0776

_____

_____
Patient Name — Signature of Patient or Representative

_____ _____
Date — Description of Representative's Authority

_____ _____
Patient Date of Birth — Printed Name of Patient or Representative

Patient Social Security Number: XXX-XX-_____
Last 4 digits only

Wellness Family Medicine FINANCIAL POLICY

Your Plan	What You Do	What We Do
Medicare	Pay your deductible ($147 for 2013) and co-insurance (20% of the allowable.)	We will file Medicare for you.
Medicare and a secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicare and Medicaid	No payment due at time of service.	We will file Medicare and Medicaid for you.
Medicaid	$3.30 co-pay at every visit	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Medicaid HMO	Your card must have the name of our provider to be seen. No payment due at time of service.	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Blue Cross Blue Shield	Pay your deductible, co-insurance or co-pay at time of service.	We will check your eligibility before every visit and will file your Blue Cross insurance for you.
Insurance we are not contracted with	Pay the visit in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
Worker's Compensation	You must have opened a claim with your employer to be seen. No payment due at time of service.	We will file your Worker's Compensation insurance for you.
Self-pay	Pay for the visit in full at time of service. We offer a 30% discount for cash at time of service.	None.

Other fees:

- Returned check fee - $30.00
- No-show fee - $25.00
- Form completion fee - $15.00 each form

PLEASE SIGN THE BACK OF THIS FORM

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of Wellness Family Medicine's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Wellness Family Medicine, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Wellness Family Medicine for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to deductible, co-payment, co-insurance are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Wellness Family Medicine.

Patient's Signature	Date
Responsible Party	Relationship to patient