WISEMAN FAMILY PRACTICE
Integrative Medicine and Total Wellness

PATIENT REGISTRATION INFORMATION

Please PRINT and COMPLETE ALL SECTIONS Below

Name: _____ _____ _____
Last Name First Name Middle Initial

Date of Birth: _____ / _____ / _____

(Please present your insurance card(s) and driver's license to receptionist at your new patient visit.)

☐Self ☐Spouse
Name of Insured: _____ Date of Birth: _____ Relationship to Insured: ☐Child ☐Other

Policy Holder #: _____ Group #: _____ Co-Pay: $_____

FAMILY HISTORY:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Other: _____

SOCIAL HISTORY:
Marital Status: _____
Diet Description: _____
Tobacco use?: ☐ Yes ☐ No Alcoholic drinks per week: _____

PAST MEDICAL HISTORY:
Any current medical complaints? _____
_____
_____
_____
Any past medical history? _____
_____
_____
_____

MEDICATIONS: List all medications and the dosage/number of pills you take per day. _____
_____
_____

DRUG ALLERGIES: List all medications to which you are allergic. _____
_____

SUPPLEMENTS: List all supplements that you are taking. _____
_____
_____

IMMUNIZATION HISTORY: Childhood vaccinations up-to-date?: ☐ Yes ☐ No
Date of last TB shot (tuberculosis): _____ Date of last Td shot (Tetanus): _____
Date of last Pneumonia shot: _____ Date of last Flu shot: _____
Date of last shot (Other): _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly the Wiseman Family Practice, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize Wiseman Family Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

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OFFICE POLICIES & CONTACT PERMISSION

Please PRINT and COMPLETE ALL SECTIONS Below

Dear Patients:

OFFICE POLICIES: Because we are subject to the increasing demands of managed care, it has become necessary to alter our office policies. Our office policies are as follows:

1) ***24-hour notice of appointment cancellation*** is necessary to assure our patients of appointment availability. Too often, appointments are missed but not cancelled, causing valuable appointment space to be lost. To minimize this problem, ***we are instituting a $25.00 "No Show Fee"*** which you will be billed for, should you fail to cancel your appointment within 24 hours.

2) ***Return phone calls***. As our providers see numerous patients during the day, it is very difficult for them to return phone calls during regularly scheduled hours. We ask that you allow up to 24 hours for us to return your phone calls with the exception of emergencies. In addition, we do not bill for any phone calls as it is a courtesy to our patients. ***If you are experiencing a life-threatening situation, please call the emergency room for immediate assessment***.

3) ***Late arrivals***. Patients that arrive late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first. ***If you arrive more than 15 minutes past your scheduled time, then your appointment will be rescheduled.***

4) ***We file insurance*** as a contractual agreement and as a courtesy. However, if we do not receive payment from the insurance company within 90 days, it then becomes the patient's responsibility, and the patient will be billed. Although we are not a Medicare provider, we will file your paperwork. Full fees are due at time of appointment. After filing your paperwork, you should receive a reimbursement from Medicare within 30-45 days.

EMAIL: In order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Wiseman Family Practice, we would like ***permission*** to use your email and/or your cellular telephone number. I understand that the above information will be kept private and confidential, and ***I give permission for Wiseman Family Practice to email and/or text me as needed.***

- Email Address: _____ Cell Phone: _____
- Printed Patient Name: _____
- Patient Signature: _____
- Date of Birth: _____

I, _____, have read and understand the policies described above.

Signed: _____ Date: _____

Patient Portal Information (FOR OFFICE USE ONLY)
Username:_____
Password:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

Please PRINT and COMPLETE ALL SECTIONS Below

Patient Name: _____

Home Address: _____

Phone: _____ **DOB:** _____

By my signature below, I hereby authorize Wiseman Family Practice ("Practice") to disclose my protected health information (PHI) so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's treatment, payment and health care operations (TPO), (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

With this consent, Wiseman Family Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance issues, and any calls pertaining to my clinical care, including laboratory results.

With this consent, Wiseman Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient financial statements. Please check your preferred contact method.

☐ Email/Patient Portal ☐ Mail ☐ Phone

With this consent, Wiseman Family Practice may speak with the following. List family members, friends, etc. whom you would like to have access to your protected health information to assist the practice in carrying out TPO, such as discussing any open or unpaid balance of my financial account, including visit reason, insurance-related matters, or any other medical issues.

Name: _____, Relationship

Name: _____, Relationship

I have the right to request that Wiseman Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Wiseman Family Practice to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wiseman Family Practice may decline to provide treatment to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wiseman Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained through our office.

I have reviewed this office's Notice of Privacy Practices (HIPAA), which explains how my medical information can be used and disclosed. I understand that I am entitled to receive a copy of this document.

Print Patient's Name: _____

Signature of Patient: _____

Date: _____

WISEMAN FAMILY PRACTICE
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Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Best Contact Number: _____

Records Release ☐ **From** ☐ **To** ☐ **STAT**

Wiseman Family Practice

2500 South Lakeline Blvd Suite 100

Cedar Park, TX 78613-2968

Phone #: (512) 345-8970 Fax #: (512) 345-6689

Records Release ☐ **From** ☐ **To** ☐ **STAT**

Name of Organization/Individual: _____

Street Address: _____

City, State, Zip Code: _____

Phone #: _____ Fax #: _____

Please Check the Following:

☐ History/Physical Exam
☐ Progress Note/Office Reports
☐ Immunizations
☐ Laboratory Reports
☐ Imaging Reports/EKG
☐ Other: _____

Reason you are requesting and/or transferring your record(s): _____

Signature of Patient: _____ Date: _____

Signature of Parent/Responsible Party: _____

Relationship to Patient: _____

Prohibition on Disclosure: *This information is being disclosed to you from confidential records. Their confidentiality is protected by law. You are prohibited from making any further disclosure on the information except with the specific written consent of the person to whom it pertains and the facility from with the information originates*