NEW PATIENT MEDICAL INFORMATION

Please PRINT and COMPLETE ALL SECTIONS Below

Name: _____ _____ _____
Last Name First Name Middle Initial

Date of Birth: _____ / _____ / _____ Pharmacy Name & Address: _____

Insurance Policyholder Name: _____
Insurance Policyholder Date of Birth: _____

REASON FOR TODAY'S VISIT: _____
_____
_____

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

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

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

MEDICAL HISTORY:
Past medical history and date of diagnosis:_____
_____
_____
_____
Past surgical history and date of procedure:_____
_____
_____

FAMILY HISTORY: Include relation and description if applicable.
Cancer:_____
Diabetes:_____
Heart Disease:_____
Other:_____

SOCIAL HISTORY:
Marital status: _____ Number of children: _____ Employment description:_____
Diet description: _____
Types of exercise:_____
Number of exercise days per week:_____
Tobacco use?: ☐ Yes ☐ No Alcoholic drinks per week: _____

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): _____

OFFICE POLICIES: Our office policies have been updated. Please read the following and sign below.

1) ***New Patient administrative fee.*** We charge a one-time $35.00 fee for all new patients that covers the administration and maintenance of your Patient Portal services, all WFP patient education, and all other non-insurances covered services our practices provides moving forward.
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 patients allow up to 24 hours for us to return phone calls with the exception of emergencies. ***If patient is 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. Should another patient with a scheduled appointment arrive at the same time, they will be seen first. ***If patient arrives more than 10 minutes past the scheduled time for a 15-minute visit, and more than 15 minutes past the scheduled time for a 30-minute visit (Physicals and New Patients), the 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 to Medicare insurance (Medicare files to secondary insurances). Full fees are due at time of each Medicare appointment. After filing the paperwork, patient should receive a reimbursement from Medicare within 30-45 days.
5) ***We provide a number of services that insurance does not cover, therefore we charge cash fees for these services. These services encompass, but are not limited to, the following:***
    - ***Triage phone nurses visit*** of $30.00 and ***Provider phone consults*** of $60.00.
    - ***Letters and Forms.*** We charge a $15.00 or $30.00 fee for all letters and forms that we complete.
    - ***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 $35.00 "No Show Fee"*** for which patient will be billed, should patient fail to cancel his/her appointment within 24 hours.
6) ***Schedule II Prescriptions (Triplicate).*** For certain classes of drugs, it is required that special prescriptions are written. The following is our policy regarding these types of medications:
    - The fee for each prescription of this kind for non-office visit refills is $15.00 for one and $25.00 for two (the second one is post-dated) at the time of pick up.
    - Only the person for whom the prescription is written may pick up, unless consent is given for someone else to do so. ID's will be checked.
    - Patient is responsible for his/her prescription. If prescription is lost or stolen, it cannot be replaced until the next renewal due date.
    - In order to renew the prescription after two refills, patient must have an appointment with a practitioner every three months.
    - Patient may not alter the prescription in any way. If there is a mistake (e.g., incorrect date), patient can call the office and we will set up a time for patient to return the incorrect one and pick up the correct one.
    - Patient must sign our Patient Responsibility Agreement for Controlled Substance prescriptions.
    - Patient will be asked to do periodic urine toxicology tests in order to receive these types of prescriptions.
7) ***Minor Patients.*** The parent or legal guardian must accompany the minor (under the age of 18) and is responsible for payment at the time of visit.
8) ***Financial Agreement/Assignment of Benefits.*** Patient hereby gives lifetime authorization for payment of insurance benefits to be made directly to Wiseman Family Practice, and any assisting physicians for services rendered. Patient understands that he/she is financially responsible for all charges whether or not they are covered by insurance. In the event of default, patient agrees to pay all costs of collections, and reasonable attorney's fees. Patient hereby authorizes Wiseman Family Practice to release all information necessary to secure the payment of benefits. Patient further agrees that a photocopy of this agreement shall be as valid as the original.

I have read, understand, and agree to the policies described above.

Patient/Responsible Party Signature: _____ Date: _____

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

Patient Name: _____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, and/or e-mail any items that assist the practice in carrying out TPO, such as test results, appointment reminders and patient financial statements.

With this consent, Wiseman Family Practice may speak with the following 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.

Printed Patient Name: _____

Signature of Patient/Legal Guardian: _____Date: _____