**Clinic W** **David S. Wilson MD**

## Patient Demographics

**MR #** _____

First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip _____

DOB: _____/_____/_____ Home PH. #: (_____) _____-_____ Cell #: (_____) _____-_____

Soc. Sec. #: _____-_____-_____ Gender: _____ Marital Status: _____

Employer: _____ Ph. #: _____

**Race:** ____ (White) _____ (Black) ____ (Asian) _____ (other) **Ethnicity:** _____ Hispanic or Latino _____Not Hispanic or Latino

Email Address: _____

## Responsible Party/ Guardian Information:

Person Responsible for Account: _____ Relationship: _____

Date of Birth: _____ SS# _____ - _____ - _____ Ph. # _____

Address: _____ City: _____ State: _____ Zip: _____

## Insurance Policy Information:

**Please provide the receptionist with current insurance cards.**

Emergency Contact: _____ Ph. #: _____

Emergency Contact: _____ Ph. #: _____

## Medical History:

Please check off if you have had any problems with or are presently experiencing any of the following:

| | | |
|---|---|---|
| ____ high blood pressure | ____ bronchitis | ____ hepatitis |
| ____ diabetes | ____ pneumonia | ____ thyroid disease |
| ____ cancer (type)_____ | ____ persistent cough | ____ headaches/migraines |
| ____ heart disease | ____ T.B. | ____ kidney disease |
| ____ chest pain/tightness | ____ indigestion | ____ arthritis |
| ____ shortness of breath | ____ nausea/vomiting | ____ low back pain |
| ____ palpitations | ____ constipation | ____ blood disorder |
| ____ dizziness | ____ diarrhea | ____ anxiety/depression |
| ____ frequent urination | ____ blood in stool | ____ anemia |
| ____ asthma | ____ ulcers | ____ alcohol abuse |
| ____ drug abuse | ____ gout | ____ colitis |

## Smoking Status:

_____ Never Smoked

_____ Former Smoker

_____ Current every day smoker; PPD: _____

_____ Year Quit

## Allergy to Medications:

_____

**Name of Medication and Strength:** **Dosage:** **Quantity:**

_____

_____

_____

_____

_____

_____

| Surgical History: |
| --- |
| _____ |
| _____ |
| _____ |
| _____ |

Medical Exam:

Last Mammogram: _____ Last Pap smear: _____

Last Prostate exam: _____ Last Colonoscopy: _____

# Permission Form

I give permission to Clinic W staff members to discuss appointment confirmations, lab results, or any relevant medical or financial information with the following:

Name: _____ Relationship: _____ Ph. # _____

Name: _____ Relationship: _____ Ph. # _____

Name: _____ Relationship: _____ Ph. # _____

*I understand that Clinic W staff members are HIPPA compliant and are not authorized to discuss anything with anyone other than myself or with whom are listed above.

Patient Signature: _____ Date: _____

## Consent for Treatment

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, and conduct of laboratory, x-ray, or other studies that may be used by the attending physician, nurse, or qualified designee.

## Financial Policy

We at Clinic W are committed to providing you with the best possible care. If you have medical insurance, we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your ins. **You must realize however, that:**

1. Your insurance is a contract between you and your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. **Co-payments must be paid at the time of service.**
4. If you have no insurance, payment for service is due at the time of service. We accept cash, checks, Master Card, American Express, and Visa Card.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered and are to be paid in full within 90 days. After the 90 days I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs if such be necessary.

We realize that temporary financial problems may arise and we encourage you to contact us promptly for assistance in the management of your account.

## Consent to Contact Debtors

You agree, in order for us to service your account or to collect monies you may owe, Clinic W and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and understand the consent for treatment, Financial Policy, and agree that Clinic W, its employees and/or agents may contact me about debts owed as described above.

# MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Clinic W, LLC. When you schedule an appointment with Clinic W we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and **no later than 24 hours prior to your scheduled appointment**. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our appointment Cancellation/No Show Policy below:

- Effective April 11, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a $25.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a **second** time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be **dismissed** from Clinic W.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due before or on the patient's next office visit.

We understand there may be times when an unforeseen **emergency** occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager. You may contact Clinic W, Monday – Thursday 8:00am – 4:30pm and Friday 8:00am – 12:00pm. Should it be after normal business hours you may leave a message. Messages left are acceptable.

# Notice of Privacy Policies & Consent Form for Clinic W, LLC

This notice describes how information about you may be used and disclosed and how you can get access to this information.

At Clinic W, LLC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This notice applies to all PHI as defined by federal regulations.

The use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriated for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes 1) our submission of your health information to a billing agent or vendor for processing claims or obtain payment; 2) our submission of claims to third-party payers or insures for claims review, determination of benefits and payment; 3) our submission of your health info to auditors hired by a third-party payers and insurers; and 4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change and an updated copy will be available to you.

**Your Health Information Rights**

Although your health record is the physical property of Clinic W, LLC, the information belongs to you. You have the right to obtain a paper copy of this notice of information practices upon request; inspect and copy your health record as provided for in 45 CFR 164.524; amend your health record as provided in 45 CFR 164.524; obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528; request communication of your health information by alternative means of at alternative locations; request a restriction on certain used and disclosures of your information as provided by 45 CFR 164.522, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities:**

Clinic W, LLC is required to maintain the privacy of your health information, provide you with this notice as our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We will not use or disclose your health information without your authorization except as described in the notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If you believe your privacy rights have been violated, you can file a complaint with the facility's Privacy Officer, or with the Office for Civil Rights, U.S. Dept of Health and Human Services. There will be no retaliation for filling a complaint with either.

By signing this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations.

**I have read these documents and understand them. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Clinic W, LLC, read and understand the medical appointment cancellation/No show Policy, consent for treatment, financial policy, and agree that Clinic W, its employees and/or agents may contact me about debts owed as described above.**

Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient.

Relationship to the Patient: _____