PATIENT REGISTRATION FORM

Today's Date: ________________________

Clinic Name: Please Check Location:

_____Family Wellness Clinic- Clayton _______Family Wellness Center Regenisis MD- Raleigh

PATIENT INFORMATION: (please use full legal name, no nicknames)

Last Name: ______________________ First Name: _______________________ Mid I: ____

Address: ____

City: ____________________________ State: ________ Zip: ________________________

Home Phone: _________________ Cell: ___________________ Work: ________________

Date of Birth: _______________ Age: ______ Marital Status: ______________

Social Security # __________________________ Sex: ___________

Drivers Lic #________________________ Drivers Lic State: ______________

Employer Name & Address: ____

Email Address: ____

Emergency Contact Name & Number: ____

Please tell us how you heard about us: ____________________ Referred by: ____________

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GUARANTOR INFORMATION: List person or insured name responsible for bill-use full legal name no nicknames

Relationship of Guarantor to Patient: Self______ Spouse______ Parent______ Other_________

Last Name:______________________ First Name:_____________________ Mid I:_______

Address: ____

City: ____________________________ State: _________ Zip: ________________________

Home Phone: _____________________ Cell: __________________ Work: _____________

Social Security #:__________________________ Sex: _______ Gender: ________________

Date of Birth: ____________________________ Age: __________

Employer Name and Address: ____

INSURANCE INFORMATION:

Please allow receptionist to photocopy your insurance cards and ID

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: ______________________________ Insured Name: ______________________________

Insured's Social Sec #: _____________________ Insured's Date of Birth: _____________________

Policy ID #: ____________________________ Group #: ____________________ Eff Date: _______

Claims Address & Phone #: ____

SECONDARY INSURANCE:

Plan Name: ______________________________ Insured Name: ______________________________

Insured's Social Sec#: _____________________ Insured's Date of Birth: _____________________

Policy ID#: ____________________________ Group#:____________________ Eff Date: _______

Claims Address & Phone#: ____

Prescription Card Information:

Rx Bin#: _______________________________________

Rx Group#:_______________________________________

Rx PCN#: _______________________________________

RX ID# ____

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:_________________________________ Date of Birth:_______________

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Raleigh Durham Medical Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Raleigh Durham Medical Group is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my or my dependents authorized benefits be made directly to Raleigh Durham Medical Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Raleigh Durham medical Group patient Information Privacy Policy. I hereby authorize Raleigh Durham Medical Group or the physician individually to release any of my or my dependents medical or incidental non public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:

I certify that I understand the privacy risks of mail, phone calls, and email. I hereby authorize a Raleigh Durham Medical Group representative or my physician to mail, call, or email with communications regarding my healthcare, including but not limited to such things as appointment reminders, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Raleigh Durham Medical Group to that effect in writing.

LAB/XRAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Raleigh Durham Medical Group physician or his or her designee.

Patient Signature: _________________________________ Date: __________________

Guarantor Signature: _______________________________ Date: _________________
(if different from patient)
Guarantor Name (please print): ____

Family Wellness Payment & Cancellation Policy

After Hours Phone Number: 919-585-5815

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this policy. Please read it, ask us questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare for established patients. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and deductibles:** All co-payments and deductibles **must** be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-Covered Service:** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You **must** pay for these services in full at the time of the visit.
4. **Proof of Insurance:** **All** patients must complete our patient information form before seeing the doctor. **We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance**. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not the party to contact.

6. **Covered Charges:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Missed Appointments:** We ask that you give us a 24 hour notice if you cannot keep your appointment. Consecutively missed appointments may result in termination. **Effective March 7, 2012 our $35 No Show appointment Policy went into effect.**
   - **$35 Missed provider appt fee**
   - **$100 Missed ultrasound appt fee**
   - **$10 Missed lab appt fee**
8. **Returned Phone Calls:** If you leave a message for a member of our staff we will return you call within 24 hours. Please do not call multiple times as it will only delay our response.
9. **Refills:** Please have your provider refill your medications at your appointment. If you have one that is missed please have your pharmacy fax us a request. We will refill the medication within 24 hours. Multiple calls or faxes will only delay our response.
10. **Complaints/Comments:** If you have any complaints or suggestions please speak with our Office Manager, Dwaina Davis, in person, at 919-553-5711 or email at Dwaina.gurley@rdmgpa.com

Family Wellness is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment and cancellation policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____________________________________ _______________

Signature of patient or responsible party **Date**

____

Relationship or status if not signed by patient

Well Visits (Physicals)

PLEASE BE AWARE:

If you have multiple concerns or chronic conditions that you would like to discuss during a well visit, these usually require a separate code and charge in addition to the well visit code per your insurance company. Addressing these concerns during a well visit may result in you being charged for an office visit copay in addition to a well visit. If you would prefer, we will schedule a separate visit to address any of these multiple or ongoing issues.

These issues include, but not limited to:

Chronic Headaches

Stomach Pains

ADHD Recheck

Asthma Recheck

Back Pain

GYN Concerns

Diabetes

Blood Pressure

Cholesterol

Hormone/Menopause Issues

Patient Name: ________________________________

Patient Signature: ____________________ Date:__________

FAMILY WELLNESS PATIENT POLICIES

In order to provide the highest quality of care and to insure that mistakes are avoided, we are implementing the following policies:

Medications

Please ask the provider for refills at your appointment. You will be given enough refills to last you until your next appointment. You must keep your appointment to receive further refills.

Appointments

1. Please contact our office at least 24 hours in advance to cancel an appointment to prevent a charge.
    - No Show for an appointment with provider=$35.00 charge
    - Cancel less than 24 hours prior to appointment=$35.00 charge
    - No Show for an Ultrasound appointment=$100.00 charge

2. You will need an appointment to come in and discuss blood work unless the provider instructs the office staff otherwise.

3. You will need to arrive 15 minutes before your appointment. We no longer have a 15 minute grace period after the appointment time. If you are not here by your scheduled appointment time there is a possibility that you may be rescheduled.

4. Any balance **MUST** be paid at the time of service along with your co-pay. Please be prepared when you arrive.

5. Please make sure to bring your insurance card(s) with you to **EVERY** appointment. There is a chance that you may not be seen if there is no card on file.

Patient Name______________________________ DOB:__________

Patient Signature______________________________ Date:___________

FWC Witness________________________________ Date:___________

FAMILY WELLNESS CLINIC
PATIENT CENTERED MEDICAL HOME (PCMH)
Patient / Provider Agreement

Good communication between patients and physicians is the key to better outcomes. My staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a dear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

– Respect you as an individual - we will not make judgments based on race, ethnicity, national origin, religion, gender, age, physical disability, sexual orientation or genetic information
– Respect your privacy - your medical information will not be shared with anyone else unless you give permission or as required by law
– Provide the best possible treatment and advice based on current medical evidence - we respect your right to information and will discuss appropriate or medically necessary treatment options regardless of cost or benefit coverage
– Manage your health status, including well person/preventive care as well as treatment for acute and chronic diseases
– Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services, and other care as needed.

What We Ask of You:

– Ask questions, share your feelings and be part of your care
– Be honest about your history, symptoms and other important information about your health
– Tell you doctor about any changes in your health and well-being
– Take your medicine as ordered and follow your doctor's advice-if you are unwilling or unable to do so, be honest with the doctor
– Make healthy decisions about your daily habits and lifestyle
– Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
– Call your doctor first with all problems, unless you have a medical emergency
– End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans

PLEASE NOTE: Our office is open 8:00a.m.- 6:00p.m. Monday, Wednesday, and Thursday and 8:00a.m. - 5:00p.m. Tuesday and Friday. When the office is closed, we have an on-call provider available for urgent issues which cannot wait until regular office hours.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

Patient Name ____________________ Patient or Representative Signature ____________________ Date ____________

Physician or Representative Signature ____________________ Date ____________

Medical Release of Information Form

Patient Name: ______________________________ Date of Birth: __________________

I request and authorize ____ to release the
(Name of Physician/Clinic/Practice & phone number)

Medical record of the above named patient to: Fax # ________________________

Family Wellness Clinic
Dr. Bhavna Vaidya-Tank
Jason Newman, PA-C
Kaddijatou Sanyang PA-C
Thanh Tran, PA-C

PLEASE DO NOT SEND RECORDS ON CD'S

2076 NC Highway 42 W, Suite 230
Clayton, NC 27520
www.claytonclinic.com
Phone: 919-553-5711 Fax: 919-553-5712

Reason for release: **Continuation of Care.**

This request and authorization applies to: (please initial appropriate line)
Please do not send the patients entire medical record, Please only send what the patient has requested. Thank You!

_____ Last 2 labs, Vaccine Records, last 2 office notes & Physicals

_____ Healthcare information relating to the following treatment or dates of service:

____

_____Healthcare information **including** information relating to HIV/AIDs testing sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

_____Healthcare information **excluding** information relating to HIV/AIDs testing sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

By signing below, I give permission to the above named organization to release information; I understand I have the right to revoke this authorization by providing a written request to do so, and that the revocation will not apply to information that has already been released. I also understand that unless otherwise revoked this will expire 6 months from the date signed.

____ ______________________
Signature of patient or authorized representative Date

____
Relationship or status if not signed by patient

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.