WIGGINGTON ROAD FAMILY PRACTICE

Patient's Name_____Sex_____
LAST FIRST MIDDLE

Address_____City_____State_____Zip_____

Phone No (Home)_____(Cell)_____(Work)_____

Social Security#_____Date of Birth_____

Marital Status (please Circle): Married Single Divorced Widowed

Name of Spouse_____

Insurance Co Name_____Policy No_____

Employer's Name_____Phone No_____

Emergency Contact name/relationship_____

Emergency Contact No_____

If patient is a minor:

Father's Name_____Phone No_____

Mother's Name_____Phone No_____

Authorization to release information and to pay benefits to Wiggington Road Family Practice.

I hereby authorize the designated physician to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures and/or services performed. If I provide incorrect information about my insurance company and the claim is denied, I will be billed the balance of the claim. I also authorize my physician to initiate a complaint to the Insurance commissioner for any reason on my behalf. I agree that default of payment will subject the account to all collection fees including court costs and attorney fees at 33.3% and interest at 18% if applicable. I agree that this authorization shall be valid until rescinded in writing or replaced by on of a later date.

_____ _____

Signature of Patient/Parent if Minor **Date**

MEDICAL HISTORY INFORMATION

Patient Name_____

Current Medical Problems_____

Past Medical History_____

Surgeries_____

Please list ALL Medications (including over-the-counter and herbals) and their dosages

_____

_____

_____

_____

Pharmacy_____

Allergies_____

Please list any medical problems of your relatives_____

_____

Number of children_____

Tobacco usage and amount_____

Alcohol or drug usage and amount_____

Do you have an Advance Directive or DNR (Do Not Resuscitate)? _____

Are your immunizations up to date? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his /her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature_____Date_____

FINANCIAL POLICY

As a courtesy to our patients, we will file your insurance if you have a copy of the card in your possession. We must have all pertinent information to extend this courtesy. If you are self-pay patient, please arrange to pay in full at the time of service.

We are participating providers for Aetna, Anthem, Cigna, PCHP, Southern Health, Tricare, United Health Care, Optima, and Medicare. You are required to pay any applicable co-pay or yearly deductible at the time of service. Our policy is to collect co-pays during the check in process.

If your insurance plan requires a primary physician (PCP), Dr. Rank's name must appear on your card to be seen.

If you have an outstanding balance at the time of your next office visit, you will be expected to pay that balance prior to being seen. If your account becomes over 90 days past due, you will receive notification stating your account is in jeopardy and may be sent to an outside collection agency. Once your account is turned over to collections, you will be discharged from the practice. The entire amount of the bill, interest, court costs, collection fees and /or attorney fees will be due, whether or no suit is commenced.

You may receive a separate bill from our outside lab, Centra Lab or Labcorp.

There will be a $25 charge for no shows or those who do not notify the office within 24 hours prior to the scheduled appointment to cancel or reschedule.

We accept Mastercard, Visa, check or cash. Please be advised there is a $35 fee for returned checks.

I HAVE READ AND UNDERSTAND THE ABOVE AND AGREE TO MY RESPONSIBILITYIES AS A PATIENT OF WRFP. I also understand and agree that I will be responsible for all fees incurred and am responsible for all collections fees and or attorney's fees if this account is turned over to a collection agency, whether or not suit is commenced.

Patient's signature_____**Date**_____
Parent's signature if patient is a minor_____

PATIENT RECORDS OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information(PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Check all that applies)

_____Home Telephone#_____
_____Ok to leave message with detailed information
_____Leave message with call back number only
_____Work Telephone#_____
_____Cell Phone#_____

_____Written Communications
_____Mail to home address
_____Mail to work address

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of PHI to a minimum and for what is necessary to accomplish the intended purposes. We will only disclose PHI to individuals who are authorized by the permission granted too us by the patient.

Please list below all individuals to whom you give us permission to disclose your protected health information:

Name/Relationship	Phone#
_____	_____
_____	_____
_____	_____

Patient Signature_____**Date**_____
Print Name_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature_____**Date**_____
Print Name_____**DOB**_____