We Care Clinic

Patient Registration Form

Patient Personal Information	
Name	
Social Security	
DOB	
Gender	
Race	
Marital status	
Language	
Email	
Address and ZIP Code	
Phone Number #1	
Phone Number #2	
Phone Number #3	
How did you hear about us?	
Employer	
Company Name	
Address and ZIP Code	
Phone Number	
Emergency Contact	
Contact Name	
Relationship	
Phone Number	
Insurance Information	
Insurance Name	
Group Name	
ID Number	
Policy Holder Name	
Social Security	
DOB	

Patient Signature Date

Insurance Member Signature Date

We Care Clinic

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ Date of Birth:_____

I understand and agree that I will be financially responsible for any and all charges for service not paid by my insurance for my visits. This includes any medical service visit, preventative exam or physical, lap testing, x-ray, EKG and any other screening service or diagnostic testing ordered by the physician or physician's stuff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the result in claims being denied or higher out-of-pocket expenses to me, I understand this and agree to be financially responsible for all the charges.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company of plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied, I understand that this and agree to be financially responsible and make full payment.

Signature:_____ Date:_____

Responsible Party Signature:_____

We Care Clinic

Patient Registration Form
Disclosure and Consents

Patient Name:_____ DOB:_____

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the **We Care Clinic** or the physician individually for services rendered to my dependents, or me, by the physician or those 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 benefits. I understand and agree that I will be responsible for any co-pay balance due that the **We Care Clinic** 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 dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to the **We Care Clinic** or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I read and been offered a copy of the **We Care Clinic** disclosure and consent form. I hereby authorize the **We Care Clinic** the physician individually to release any of my, or my dependents medical or incidental nonpublic 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 the mail, phone calls, the e-mail. I hereby authorize the **Clinic name** representative or my physician to mail, call, or e-mail me with communications regarding my health are, including, but not limited to sure things as appointment reminders, referrals arrangements, and diagnostic test results. I understand that I have the fight to rescind reminders, referral arrangements and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying the **We Care Clinic** to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

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

CONSENT TO TREATMET:

I hereby consent to evaluation, testing, and treatment as directed by the **We Care Clinic** physician or those under his/her supervision.

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date: _____

Guarantor Name (Please Print):_____

We Care Clinic

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages on a voicemail at home or on your cell phone to discuss appointments or treatments? Yes No N/A

May we discuss your appointments/treatment with your spouse? Yes No N/A

May we leave messages concerning your appointments with a coworker, receptionist or secretary that regularly answer you calls? Yes No N/A

May we leave messages on a voicemail at work? Yes No N/A

If you are over the age of 18, may we discuss your appointments and/or treatment with your children? Yes No N/A

You must inform us, in writing, of any changes in your directives, This record will take effect immediately and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

I acknowledge I have received a copy of the "Notice of Privacy Practices"

Signature:_____ Date:_____

Printed Name:_____ Date of Birth _____

Relationship if Patient Representative to Patient_____

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We Care Clinic Patient Contract

I,_____ , on this _____(Date) understand and voluntarily agree that (initial each statement after reviewing):

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients I will be fired from the clinic.

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team. I understand that there is a 25 dollar charge if I do not cancel or reschedule my appointment within 48 hours of the scheduled time.

_____I will complete all diagnostic tests (labs, x-ray, EKG, etc.) in a timely fashion prior to my next appointment.
_____I will pay all my deductibles on the day of my visit and pay all balances owed.
_____I will carry and provide my insurance card on each visit.
_____I will notify the office immediately of any changes in insurance and provide a copy of my insurance card on my next visit.
_____I will notify the office if any contact information changes occur.
_____I will bring all my medication to all my appointments EVERYTIME. I understand that mistakes occur and my provider and his team require the actual medication bottles and not a list to ensure my safety.

_____I will keep all my medications safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will call at least 3 weeks in advance if my medications are running out and my next appointment is more than 3 weeks away.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will not call after business hours, at night, or on the weekends looking for refills. I understand that prescriptions will be filled only during business hours. I also understand that if I miss or reschedule an appointment, I will only be given enough of my medications to last till my next visit.

_____I will use only one pharmacy to get all on my medicines:
Pharmacy name/phone#_____

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

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_____I will sign a release form every time I go to the Emergency room or to the hospital the day after I am released and make an appointment to see the doctor within a week of my release or discharge.

My health is important to me, my family, and loved ones. I will work hard to care for myself. I understand that my doctor cannot help me if I will not help myself. I expect my doctor to offer me his/her best advice based on his/her medical training. I understand that, without my active participation, my doctor's ability to help me is limited. I understand that my doctor is the consulting partner, I am the working partner. Working together, we can accomplish great things.

Patient's signature:_____
Date:_____

We Care Clinic Commitments

We here at the We Care Clinic are making a commitment to work with you in your efforts to improve your overall health. To help you with this, we agree that:

We will treat you with respect at all times. If any member of the clinic fails to do this, please address our clinic manager.

We will explain your medical problem(s) and provide you treatment options.
We will help connect you with other forms of treatment to help you with your condition.
We will help set treatment goals and monitor your progress in achieving those goals.
We will stay in contact will all providers involved in your care.
We will explain what new medications are for and possible side effects. We will make sure that this treatment is as safe as possible.
We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.