Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name		Date of Birth	Age	Patient Gender ☐ M ☐ F
Street Address	City	State	Zip Code	Social Security Number	
Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary	Email Address		
Need Interpreter? ☐ Yes ☐ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ☐ Yes ☐ No	Race / Religion
Employer Name	Employment Status ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student				
Employer Address	City	State	Zip Code	Employer Telephone	
Emergency Contact Last Name	First Name	Pharmacy Name/Number/Location			
Emergency Contact Relation to Patient	Legal Guardian? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Visually Impaired? ☐ Yes ☐ No	Home Telephone ☐ check if primary	Work Telephone ☐ check if primary / Cell Telephone ☐ check if primary
Primary Care Physician					

2. Responsible Party / Guarantor ☐ **(Check if self and skip this section)**

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code
Guarantor Relation to Patient	Guarantor Gender ☐ M ☐ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student			Employer Telephone	

3. Medical Insurance Policy Holder ☐ **(Check if self and skip this section)**

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relation to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relation to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WeCareMD to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Signature of Patient/Legal Guardian:	Date:

We Care M.D.
...we really do care!

Patient History

Patient Name_____ **DOB**_____

Medication/dosage (include all supplements)	Surgeries/dates	Allergies

Do you have any of the following medical conditions?
☐ Diabetes ☐Arthritis ☐Aids ☐Asthma or lung ☐Heart ☐Stroke ☐Cancer
☐Seizures ☐Reflux ☐High Blood Pressure ☐Mental/Nervous Disorder
List any other_____

Do any of the following medical conditions run in your family?
☐ Diabetes ☐Arthritis ☐Aids ☐Asthma or lung ☐Heart ☐Stroke ☐Cancer
☐Seizures ☐Reflux ☐High Blood Pressure ☐Mental/Nervous Disorder
List any other_____

Do you currently smoke? **☐Yes ☐No Packs per day___ for ___ years**
Are you exposed to second hand smoke? **☐Yes ☐No**
Did you ever smoke in the past? **☐Yes ☐No Packs per day___ for ___years**
Do you drink alcohol? **☐Yes ☐No Drinks per week_____**

CANCELLATION - NO SHOW POLICY

Patient Name:_____ DOB:_____

Please note that appointments must be cancelled 24 hours in advance of your appointment. If you fail to call us 24 hours in advance, your appointment is considered a "no show". In order to give you the very best medical care, your compliance with appointments is necessary. All "no show" appointments will assess a $50.00 fee for regular office visits, and $75.00 for annual physicals.

After the 2rd no show, in one year, it will be necessary to discharge you from our practice.

No fee is assessed if appointments are cancelled within 24 hours. However, due to the importance of medical compliance, six cancellations will result in dismissal from our practice.

We appreciate your assistance in giving you the best medical care available.

_____ _____

(Patient signature) (Today's date)

WELCOME TO WECAREMD

We are committed to giving you the care you need with the attitude you deserve. Please assist us in giving you the best healthcare experience possible. Please note our office polices below, and if you have any questions, please feel free to ask one of our friendly professionals on staff.

FINANCIAL POLICES

We participate in most healthcare plans. It is the patient's responsibility to make sure we have the most recent insurance information on file. **If we are not contracted with your insurance company, we require full payment at the time of service**. Furthermore, if WeCareMD has filed your claim and not received payment from your insurance within 90 days, the remaining balance is the patient's responsibility, and it is up to the patient to obtain reimbursement from their insurance. Due to contractual agreements with managed care plans and in accordance with the Office of Inspector General, **we are legally obligated to collect your co-pay**. **All co-pays, deductibles, co-insurance and self-pay fees are due at check in**. We accept the following methods of payment:

- Cash
- Credit/Debit cards
- Checks
- *PLEASE NOTE THAT CHECKS ARE NOT ACCEPTED FOR THE WEIGHT LOSS PROGRAM

HEALTHCARE POLICIES

WeCareMD is a full service family practice facility. We treat most minor illnesses and we are happy to manage your overall healthcare, and refer out to other specialists when necessary. **However, we reserve the right to withdraw from treating you if we feel the doctor/patient relationship isn't compatible, or if we feel prescription medications are being abused or for medical or financial non-compliance.**

APPOINTMENT NO-SHOW POLICY

Due to the high volume of calls we receive for appointments, it is our policy that 24 hours notice is required for cancellation. Failure to call 24 hours prior to your appointment to cancel will result in a no-show charge of $50.00 for routine or sick appointments and $75.00 for annual exams or procedures. Two no-shows will result in termination of care at WeCareMD.

PRESCRIPTION POLICIES

Prescription refills can take 24-48 hours to complete. It is necessary for you to call the office well enough in advance so that your prescription can be refilled prior to running out. Some prescriptions require labs prior to each refill, and some require the doctor to assess your condition prior to refilling. Please communicate with our office if you feel your medication will require such services. ****Prescriptions are refilled during regular office hours only and will not be issued on weekends, holidays or after hours.****

AFTER HOURS CARE

Treatment is rendered during regular office hours only. If you are having a medical emergency, please call 911 or report to the nearest emergency room. Please inform the hospital staff if we are your primary care physician and they will be sure to contact us.

Signed_____ Date_____

Medical Information Release Authorization

Patient Name	Birth Date	Social Security No.
Address	Home Telephone: ( ) Alternate Telephone: ( )	

I hereby authorize the release of information from my medical records at

_____ (physician's office/facility) to **WeCareMD**,
5610 Wendy Bagwell Parkway Suite 103 Hiram, GA 30141
770-943-7808 (Phone) 770-943-7805 (Fax)

Name, address and phone number of physician's office/facility in which records are being requested

Purpose of Disclosure: (A reason must be provided)

☐ At the request of the individual signing this authorization

☐ Other (Specify): _____

For the following treatment dates:

☐ All dates of treatment

☐ For dates of treatment from _____ to _____

Type of Access Requested	**Specific description of information to be disclosed:**
☐ Copies of the record(s)	☐ All records for the time period indicated above
☐ Inspection of the record(s)	☐ Other (Specify): _____

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the WeCareMD office indicated above, except to the extent that action has already been taken in reliance on this authorization. Aside from this, I understand that upon expiration of the authorization, no further disclosure of the information may be made. I understand that WeCareMD may decline to treat me if I refuse to sign this authorization only when the treatment is for the sole purpose of creating health information for disclosure to a third party. **I further understand that the records/information to be released may contain or consist of information related to the following: contagious diseases (HIV/AIDS, tuberculosis, hepatitis, etc.); psychiatric treatment or psychotherapy; and drug/alcohol abuse treatment.**

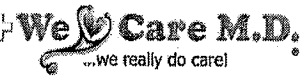
Date	Signature of Patient or Person Authorized to Act on Patient's Behalf	Relationship to Patient

This authorization expires 90 days from the date specified above or the date on which the requested release of information has been completed, whichever comes first. This release covers records of treatment only for the dates specified above.
Fees/Charges will comply with all laws and regulations applicable to release of information.

Office Use Only:

Request for Copies Completed:		Record Inspection:	
Date	By (Signature)	Date of Review	Facility Representative Present for Review

Patient Communication Designation



The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information (please print clearly):

Last Name | First Name | Middle Initial

Date of Birth (Month/Day/Year)

Street Address | Apt. #/P.O. Box# (Please Include Complete Mailing Address)

Medical Record # / Social Security # (Optional)

City | State | Zip Code

Primary Contact Number

If we cannot reach you at the telephone number listed above, WeCareMD may contact you (including leaving messages) regarding appointments or normal lab results at the following number(s):

Home Phone Number | Cell Phone Number | Work Phone Number

I authorize WeCareMD to disclose Protected Health Information to the following persons:

☐ Spouse: _____
Name | Phone Number

☐ Child(ren): _____
Name | Phone Number

_____
Name | Phone Number

☐ Other: _____
Name | Phone Number

Information to be disclosed:

☐ All Medical Information / Lab Results

☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WeCareMD location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WeCareMD cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WeCareMD is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:
(date authorization signed by patient or Legal Guardian/Personal Representative)

Month/Day/Year

Print Patient Name or Name of Legal Guardian/Personal Representative | Signature of Patient or Legal Guardian/Personal Representative

Indicate Relationship to Patient **(required)**

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*