WIMC PATIENT REGISTRATION

Patient name_____ Birth Date_____

Address_____ City/State/Zip_____

Email address_____

Home phone_____ Cell Phone _____Work Phone_____

Sex: ☐M ☐F ☐Other

Pharmacy: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partner ☐Legally Separated

Preferred spoken language: ☐English ☐Spanish ☐ Other

Do you require translation (written/verbal) services? ☐Yes ☐No ☐ Language: _____

Race: ☐Black or African American ☐White ☐Asian ☐ American Indian or Alaska Native

☐Native Hawaiian or other Pacific Islander ☐ Prefer not to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Prefer not to report

EMERGENCY CONTACT AND/OR CAREGIVER

Emergency contact name: _____ Relationship to patient: _____

Home Phone_____ Cell Phone_____

Caregiver name: _____ Phone_____

PAYMENT POLICY

All copayments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company. If your deductible has not been met or a percentage is your responsibility, payment is expected at the time of service. If you are responsible for any balances due after the insurance claim is processed, the balance will be billed via a statement.

_____Patient/Legal Guardian Initials

ASSIGNMENT OF BENEFITS

I authorize WIMC to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to WIMC. I certify that the information I have reported regarding my insurance coverage is correct, I understand that I am responsible for payment of all medical services rendered. Any check sent to me by my insurance company will be forwarded to this medical office to apply to my account, should a balance exist. This assignment will remain in effect until revoked by me in writing.

_____Patient/Legal Guardian Initials

CONSENT TO TREAT

I voluntarily consent to receive medical and health care services provided by WIMC physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatments. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will ne valid and remain in effect if I receive services from WIMC, unless revoked by me in writing with such written notice provided.

_____Patient/Legal Guardian Initials

AUTHORIZATION TO RECEIVE PRESCRIPTION HISTORY

I authorize WIMC and affiliated providers to electronically retrieve my external prescription history. I understand that prescription history may be viewable by my providers and staff here. I understand that WIMC will use my external prescription history to provide me with medical treatment and to evaluate and improve patient safety and the quality of care.

_____Patient/Legal Guardian Initials

NOTICE OF PRIVACY POLICY

WIMC Privacy Policy is available to review upon request. I acknowledge notice of Privacy Policy.

_____Patient/Legal Guardian Initials

NOTICE OF TELEHEALTH/TELEMEDICINE SERVICES

I received notice of my rights regarding telehealth/telemedicine. A copy will be provided upon my request.

_____Patient/Legal Guardian Initials

CONSENT FOR PHOTOGRAPHY AND VIDEO

I consent to WIMC taking my image for use in treatment, payment or for health care operations. I understand that my image, including photographs and audio/video recordings, will be for assisting in my care, payment or health care operations including quality initiatives. I understand the WIMC will own these images. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

_____Patient/Legal Guardian Initials

CONSENT FOR DIGITAL COMMUNICATIONS

By providing my telephone number to WIMC, I agree to receive automated calls, prerecorded messages, and/or voice or text related to my health care from WIMC. I agree to receive text messages, appointment reminders and clinic-related notifications on the phone number. I also understand that these text messages may contain PHI (Protected Health Information). Text messaging is not a secure method of communication and carries some risk of being read by a third party. I may recode or withdraw my consent at any time. Withdrawal of consent must be made in writing.

_____Patient/Legal Guardian Initials

HIPAA Release of Information:

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, _please list the names of who is authorized:

☐Appointments ☐Billing ☐Health/Medical Treatment

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