PATIENT REGISTRATION

WeCare Medical Associates

Referring Physician: _____

Primary Physician: _____ Telephone: _____

Pharmacy: _____ Telephone: _____

PATIENT INFORMATION

Patient First Name:	M.I:	Last Name:	Date of Birth / /
Social Security Number:	Age:	Gender (Circle): Male Female	Race (Circle): Caucasian Hispanic Asian African American Native American Other (Specify):
Mailing Address:	City:	State:	Zip Code:
Residential Address (if different from mailing):	City:	State:	Zip Code:
Home Phone #: ( )	Work Phone #: ( )	Marital Status (Circle): Single Married Other Divorced Widowed Separated	

EMERGENCY CONTACT INFORMATION

Name:	Home Phone #	Relationship to Patient:
	Work Phone#	
	Cell Phone #	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Patient First Name:	M.I:	Last Name:	Date of Birth / /
Social Security Number:	Age:	Relationship to Patient:	
Address:	City:	State:	Zip Code:
Home Phone #: ( )	Work Phone #: ( )	Cell Phone #: ( )	

1st PRIMARY INSURANCE FOR PATIENT

Insurance Name:

Insurance Phone #:

Insurance Address:

Policy or ID # :

Group #: (if applicable)

Date Insurance Effective:

Policy Holder Information:

Policy Holders Name:

Relationship to actual Patient:

Date of Birth:

Social Security #

Employer:

Employer Phone #:

2nd SECONDARY INSURANCE FOR PATIENT

Insurance Name:

Insurance Phone #:

Insurance Address:

Policy or ID # :

Group #: (if applicable)

Date Insurance Effective:

Policy Holder Information:

Policy Holders Name:

Relationship to actual Patient:

Date of Birth:

Social Security #

Employer:

Employer Phone #:

Please let us know if you require assistance in completing this form. We'd be glad to help.

PATIENT HISTORY FROM

NAME_____

REASON FOR VISIT_____

PAST MEDICAL HISTORY (PLEASE LIST ALL MEDICAL DIAGNOSIS AND DATE OCCURED)

PAST SURGICAL HISTORY (PLEASE LIST ALL SURGERIES/DATES)

MEDICATIONS (PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING)

Pharmacy Name and Phone #

ALLERGIES

Do you have drug allergies? Yes □ No □ If yes, please list: _____

Other allergies: _____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY, IF YES,EXPLAIN)

	Cancer	
	Heart Disease	
	Diabetes	
	Other	

REPRODUCTIVE HISTORY

- Date of Last Menstrual Period_____
- Age at First Menstrual Period_____
- If menstrual period has stopped, age of last period_____
- Sexually Active? Yes □ No □
- Type of Contraception: _____
- Are Your Periods Regular? Yes□ No□

  If No, Please Explain _____
- Do You Experience Clots While Menstruating? Yes□ No□

  If Yes, Please Explain _____
- Do You Have Problems With Break Through Bleeding? Yes□ No□

  If Yes, Please Explain _____
- Are You On Hormone Replacement Therapy? Yes□ No□

  If Yes, Name of Drug and Dosage _____

Total # of Pregnancy(ies)		Full Term Birth(s)		Premature Birth(s)	
Abortion(s)		Miscarriage(s)			

	Child's Name	Date of Birth	Birth Weight	Doctor's Name	Delivery Method	Complication
1.						
2.						
3.						
4.						
5.						
6.						
7.						

SOCIAL HISTORY

Marital Status: Single □ Married □ Divorced □ Separated □ Other_____

Do You Smoke? Yes □ No □ If Yes, How Many Packs Per Day:_____

Do You Drink? Yes □ No □ Use Drugs? Yes □ No □

Have You Experienced Depression or Domestic Violence? Please Explain Below (confidentiality is guaranteed)

_____

_____

SCREENING QUESTIONNAIRE

Please Check "Yes" or "No"

1. Do You Have Heavy Periods? _____ Yes □ No □
2. Do You Have Pain With Periods?_____ Yes □ No □
3. Do You Have Pain With Intercourse?_____ Yes □ No □
4. Are You Interested in Permanent Contraception?_____ Yes □ No □
5. Do You Have Fibroids?_____ Yes □ No □
6. Do You Leak Urine?_____ Yes □ No □
7. Do You Leak Urine With a Strong Urge on the Way to the Bathroom?_____ Yes □ No □
8. Do You Leak Urine When You Cough, Sneeze, Laugh, Lift or Exercise?_____ Yes □ No □
9. Do You Wear Pads to Protect Your Clothes From Urine Leaking?_____ Yes □ No □
10. Do You Urinate Frequently Throughout the Day?_____ Yes □ No □
11. Do You Wake Up at Night to Urinate?_____ Yes □ No □

WeCare
Medical Associates

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

HISTORY OF EXAMS	DATE/YEAR	PHYSICIAN/OFFICE
Last known Annual Exam:		
Last Mammogram:		
Last Bone Scan:		
Last Colonoscopy:		
Last known Dental Exam:		
Last known Eye Exam/Diabetic Eye Exam:		
Last Abdominal Aortic Aneurysm(AAA) Screening:		
Diabetes - Hemaglobin A1C:		

IMMUNIZATIONS		
	Date	Location
Flu Vaccine		
Pneumonia Vaccine		
Varicella (chicken pox) Vaccine		
Tetnus Vaccine		

FALL SCREEN					
Have you fallen in the past 6 months?	Yes	No			
Do you worry about falling?	Yes	No			

DEPRESSION SCREENING					
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every Day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed or hopeless	0	1	2	3	
	Total Score:				

PLEASE BRING ALL MEDICATIONS IN THEIR BOTTLES TO EVERY VISIT

Patient Signature: _____ **Date** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of WeCare Medical Associates to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waved.

_____ I do not authorize WeCare Medical Associates to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize WeCare Medical Associates to verbally release any or all information concerning my medical care to the following individuals.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

Print Patient Name: _____ D.O.B: _____

Witness Signature: _____ Date: _____

611 Jefferson Davis Hwy Ste101 Fredericksburg. VA 22401 WWW.WECAREMA.COM

HIPAA NOTICE OR PRIVACY PRACTICES

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVEIW IT CAREFULLY.

Once you sign our Patient Information consent form, we may use and disclose your medical information in order to treat you, obtain payment, and to operate the practice.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your Protected Health Information (PHI) and how you can get access to this information. "Protected Health Information" is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

Uses and Disclosures of Protected Health Information: We may use and disclose your Protected Health Information for purposes of healthcare treatment, payment and healthcare operations as described below.

For treatment: We may use and disclose your Protected Health Information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your protected Health Information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment

For Healthcare Operations: We may use and disclose your Protected Health Information in performing business activities that we call "healthcare operations". This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training f medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine, leaving messages at your place of employment or sending out recall notices. We may use or disclose your Protected Health Information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your written Authorization: Under the health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your Protected Health Information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research, Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Worker's Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your Protected Health Information for treatment, payment or healthcare operations, You may make this request in writing, at any time. If we do agree to the restriction, we will honor the restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matter in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if your are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reason for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically, You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You may Issue a Complaint to our Privacy Officer (Katelyn Hurd: Info@wecarema.com 540.656.2950) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated and not handled to your satisfaction by the Privacy Officer Listed. We will not retaliate against you for filing a complaint.

Appointment Reminders, Your health information will be used by our staff to send you appointment reminders, ultrasounds to smart phones, etc.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all Protected Health information we already have about you as well as any Protected Health Information we create or receive in the future. If we make any changes we will:

1. Post the revised Notice in our office, which will contain the new effective date; **and**
2. Make copies of the revised Notice available to you upon request (either at our offices or through the contact person listed on the Notice.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The practice(s) listed above reserves the right to modify the privacy practices outlines in the notice.

I have received or have been offered a copy of the Notice of Privacy Practices for the practices listed above.

_____
Name of Patient **(Print)**

_____
Signature of Patient or Responsible Party

_____
Date

The notice was revised and effective 11/28/2016

WeCare
Medical Associates

In an effort to serve all of our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Policies and Procedures Agreement

Patient Information and Insurance Cards: Your personal information sheet and insurance cards are an important part of your medical record. It is your responsibility to make sure you update this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep you insurance and contact information updated to insure you receive proper care.

Late Policy: Every effort is made to keep our physicians schedules on time; therefore if you are more than 15 minutes late, we reschedule your appointment to the next available with a physician in the office; however there is no guarantee that you will be seen immediately or by the originally scheduled physician. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments, Procedures, or Surgeries: Every effort is made to accommodate our patients request for appointment; therefore it is important that you make every effort to keep your scheduled appointments. Cancellations of less than 24 hours for missed office appointments/no show appointments will be subject to a fee of **$50**. Please be advised that chronic missed appointments may result in dismal from our practice.

Fee for the Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from the administrative and nursing staff as well as the doctors; therefore a fee of **$25** will be charged for the completion of forms or the writing of letters. Once the **$25** fee is paid for the first form, each form thereafter will be **$15** per form. ***Forms include all forms, reports, and letters.

Transferring of Records: All patients must sign a release of records form to have their records copied or sent to another provider organization. Copies will be provided to the patient for a **$10** administrative fee plus **$0.50** per page up to 50 pages and **$0.25** thereafter. There is no fee to transfer records directly to another provider or organization.

Payment for Services for Patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment at the time of service. Co-pays that are not paid at the time of service will be billed with an addition **$10** fee. This fee is necessary to cover administrative and supply costs when billing for co-pays. If we participate as providers with your health plan we will bill your insurance company for your visit. If we are not contracted with your insurance company, you are responsible to pay for your visit after the services are rendered. WeCare Medical Associates files your insurance as a courtesy. We ask if your account remains unpaid after 45 days that you contact your insurance company for payment.

Payment for Services for Patients without Insurance: You will be responsible for payment by cash, check, or credit card on the day of service. On bills with extensive procedures and by approval of our billing department and office manager, you may set up a payment plan with our office. (* Returned Checks: There is a $50 fee for returned checks.)

Permission for access to Pharmacy Data Bases to Obtain Medication History: YES NO (Circle one)

PATIENT SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

Payment Policy:

Insurance: We Participate in most health insurance plans, including Medicare. If you are not insured by a plan we do business with or are not insured, payment in full is expected at each visit. If you are insured by a plan we do business with but do not 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. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If any disputes/disagreements between your insurance plan and you regarding if and when you were/are covered should arise, payment in full by you will be required regardless of your dispute/disagreement.

Medicare Part B Patients: We participate with Medicare Part B. Medicare does not cover all healthcare services. In the event a service is needed that Medicare Part B will/does not cover, you will be advised prior to providing the service that is not covered by Medicare and provided with an Advanced Beneficiary Notice (ABN). This document is required by Medicare and will explain what the service is that is not covered and why it is not covered by Medicare, allowing you to make an informed decision on whether or not you still require the service in question. By signing this form, you hereby authorize WeCare Medical Associates, LLC to release information required by the Social Security Administration or it's intermediaries for purposes of medical claims. Additionally, you hereby agree and assign the benefits payable for covered services to WeCare Medical Associates, LLC and/or its healthcare providers.

Co-payments and Deductibles: All co-payments and deductibles must be paid at the time of service. Co-payment is for specialist services. This arrangement is part of your contract with your insurance carrier and our contract with your insurance carrier. Failure on our part to collect co-payments and deductibles from patients can be considered fraud and is a violation of our contract and your responsibility with your insurance plan. Please help us in upholding both of our contractual obligations by paying your co-payments at the time of service.

Non-Covered Services: Please be aware that some or perhaps all of the services you receive may be non-covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. An example of some items that may not be covered is medical supplies and equipment and copies of your medical records.

Proof of Insurance: All patients must fully complete our patient information form before seeing a healthcare provider. We must obtain a copy of photo identification and a current, valid health insurance card that provides coverage for the date(s) for which you are provided a service by us.

Claims Submissions: If you have an insurance plan with which we participate with, we will submit your claims to the insurance plan and assist you in any way we reasonably can to help get your claims paid. Your insurance plan 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 a party to that contract.**

Payment Arrangements: Payment arrangements/Payment plans can only be made at the time services are provided.

Nonpayment: If any balance due by you is over 90 days past due, you will receive a statement stating that this is your final notice and that payment in full must be received immediately. If said balance remains unpaid, we may refer your account to a collection agency.

Collection Agency: In the event an unpaid balance by you is referred to a collection agency, you hereby agree to pay 18% interest per annum, plus attorneys fees which are hereby stipulated to be 33 1/3% of the outstanding balance, plus court costs in addition to the outstanding balance whether or not suit is filed.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

Authorization to Release Confidential Medical Information

I, _____ authorize the following:

FROM:

Name of Doctor's Office: _____
Name of Physicians: _____
Street Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

TO:

611 Jefferson Davis Hwy Ste101 Fredericksburg, VA 22401 wecarema.com
www.facebook.com/wecaremallc
Phone: 540.656.2950 Fax:540.656.2957

Patient Name: _____
Date of Birth: _____

Information to be Released (check all that apply):
____Summary ____Med List ___Last 2 Office Visits
____ Last Set of Labs (CBC,CMP, TSH, Vitamin D, ETC)
___Specialist Consult

Comments: _____

VA law allows for copy charges of the following: $10.00 administrative free PLUS $.50 per page for the first 50 pages and $.25 per page thereafter, and $1.00 per page of microfilm/fiche. I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release WeCare Medical Associates to from, and release and covenant not to sue WeCare Medical Associates for any claim that I have or may have in the future for release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may request to inspect or copy information at any time except where actions have already been taken on the basis of the release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event, or condition described as:

Patient Signature/Responsible Party: _____ Date: _____
Witness Signature _____ Date: _____