Patient registration form

PATIENT INFORMATION

Please Print

□ Dr. □ Mr. □ Mrs. □ Ms. □ Jr. □ Sr. □ Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____
Also Known As Name (last _____ (first) _____
Physical Address _____
City, State, ZIP _____
Mailing Address _____
City, State, ZIP _____
Employer_____Employer Address _____
Alternate Contact Name _____ Phone Number _____
Patient Relationship to Alternate Contact _____
Marital Status □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other
Employment Status □ Employed □ Full-time □ Part-time □ Retired □Full-Time Student □ Part-time Student
□ Retired □ Self-employed □ Unemployed
Phone Numbers Home _____ Work _____ Cellular_____
□ Female □ Male Social Security Number_____-_____-_____ Date of Birth ____/____/_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First)_____ (Middle) _____
Also Known As Name (Last) _____ (First) _____(Middle) _____
Mailing Address_____
City, State, ZIP _____
Employment Status □ Employed □ Full-time □ Part-time □ Retired □Full-Time Student □ Part-time Student
□ Retired □ Self-employed □ Unemployed
Phone Numbers Home _____ Work _____ Cellular_____
□ Female □ Male Social Security Number_____-_____-_____ Date of Birth ____/____/_____
Co-payment Amount _____ Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured _____
Insurance Company Name _____ Phone Number _____
Subscriber ID (Policy Number) _____ Group ID _____
Effective Date _____ Termination Date _____ □ Female □ Male
Insured Date of Birth ____/____/_____ Insured Social Security Number _____-_____-_____
Insured Employer _____ Employer Address _____
Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured _____
Insurance Company Name _____ Phone Number _____
Subscriber ID (Policy Number) _____ Group ID _____
Effective Date _____ Termination Date _____ □ Female □ Male
Insured Date of Birth ____/____/_____ Insured Social Security Number _____-_____-_____
Insured Employer _____ Employer Address _____
Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize the release of any information requested by my insurance carrier(s) that is necessary to process unpaid claims and also authorize payment "assigned" insurance benefits to Wheat Medical Center

DOES ANYONE HAVE MEDICAL POWER OF ATTORNEY ON YOUR BEHALF? YES / NO

Patient (or Responsible Party) Signature _____ Date _____

HISTORY

PREVENTIVE SCREENINGS:

Please indicate when you last had any of the following preventative tests or services:

□ Cardiac Angiogram	□ Flu Vaccine	□ PSA Blood Test	□ Colonoscopy
□ Stress Test	□ EKG	□ Colon Cancer	□ Pap smear
□ Chest X-Ray	□ Flexible Sigmoidoscopy	□ Echocardiogram	□ Bone Density

□ Other _____

FAMILY MEDICAL HISTORY:

Please LIST OR CHECK any major illness in your family members: (mother, father, brother, sister, or children)

□ Tuberculosis	□ Diabetes mellitus	□ Kidney Disease	□ Breast Cancer
□ Emphysema	□ Thyroid Disease	□ Epilepsy	□ Ovarian Cancer
□ Heart Disease	□ Anemia	□ Neurologic Disorder	□ Colon Cancer
□ High Blood Pressure	□ Hemophilia	□ Liver Disease	□ Prostate Cancer
□ Osteoporosis	□ High Cholesterol	□ Hepatitis	□ Skin Cancer

□ Other:

_____

_____

_____

MOTHER: LIVING or DECEASED

FATHER: LIVING or DECEASED

BROTHERS: _____ LIVING, _____ DECEASED

SISTERS: _____ LIVING, _____ DECEASED

CHILDREN: _____ LIVING, _____ DECEASED

SOCIAL HISTORY:

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

Current occupation _____

Number of people living in your home _____

Have you ever felt threatened or do you currently feel threatened (emotionally/physically) in your home?

_____

Risk Reduction:

Do you use tobacco products? _____ If so, how much: _____

Do you or have you used recreational drugs (marijuana, heroin, cocaine, LSD, etc)? _____

Have you ever received treatment for substance abuse: _____Yes _____No

If yes, where?_____

How much alcohol do you consume weekly? □ None □ 0-5 □ 6-12 □> 12

If you would like to view your records online using www.myHealthware.com please provide us with your email address. You will receive an email request from myHealthware to set up an account, then just follow their instructions. Email address: _____

Patient signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

HISTORY

PATIENT NAME: _____ **DATE:** _____
DOB: _____ **GENDER: M/F**
PHARMACY: _____ **PHONE NUMBER:** _____

*******PLEASE ANSWER EVERY QUESTION**

PAST MEDICAL HISTORY:

□ Diabetes	□ Chest pain/Angina	□ High blood pressure	□ Heart Disease
□ High Cholesterol	□ Headaches	□ Kidney disease	□ Cancer
□ Osteoporosis	□ Asthma/COPD	□ Stroke/CVA/TIA	□ Seizures
□ HIV/AIDS	□ Hepatitis	□ Digestive diseases	□ Liver Disease
□ Arthritis	□ Thyroid disease	□ Depression/Anxiety	□ Trauma/Injury

Please list any major illnesses not mentioned above that have been treated in the past 3 months:

_____
_____
_____

PAST SURGICAL HISTORY:

□ Lumbar spine	□ Cervical spine	□ Coronary bypass	□ Hip surgery
□ Gall bladder	□ Appendix	□ Tonsillectomy	□ Knee surgery
□ Carpal tunnel	□ Hysterectomy	□ Coronary stent	□ Shoulder surgery

Please list any other previous surgeries not mentioned above:

_____
_____
_____

PLEASE LIST ANY RECENT HOSPITALIZATIONS:

_____

CURRENT MEDICATIONS:

_____
_____
_____

ALLERGIES:

_____
_____
_____

IMMUNIZATIONS: UP TO DATE: YES NO
IMMUNIZATIONS NEEDED: _____

WHEAT MEDICAL CENTER

Patient Name_____ **DOB:**_____ **Date:**_____

REVIEW OF SYSTEMS:

General:
- □ Increase in or loss of appetite
- □ Weight gain or loss
- □ Fever, chills, night sweats
- □ Weakness or fatigue
- □ _____
- □ No complaints

HEENT:
- □ Eye pain, watery itchy eyes, blurry vision
- □ Runny nose/ sinus pain
- □ Ear pain, drainage, hearing loss
- □ Sore throat, hoarseness, swallowing difficulty
- □ _____
- □ No complaints

Psychiatric:
- □ Anxiety, depression, suicidal thoughts
- □ ADD/ADHD
- □ _____
- □ No complaints

Endocrine:
- □ Cold or heat intolerance
- □ Hair Loss
- □ Excessive thirst or urination
- □ Diabetic
- □ _____
- □ No complaints

Cardiovascular:
- □ Chest pain, pressure, discomfort, or palpitations
- □ Irregular heart beats
- □ High blood pressure _____
- □ Blood clot, cold or purple veins
- □ Ankle or leg pain, swelling or cramps
- □ Hyperlipidemia
- □ _____
- □ No complaints

Respiratory:
- □ Shortness of breath
- □ Wheezing
- □ Cough
- □ Cough with production
- □ Snoring
- □ Sleep apnea
- □ Fluid in lungs
- □ _____
- □ No complaints

Allergies:
- □ Asthma
- □ Hives
- □ Eczema
- □ Rhinitis
- □ _____
- □ No complaints

Gastrointestinal:
- □ Nausea/vomiting
- □ Frequent heartburn
- □ Abdominal pain/bloating cramps
- □ Hemorrhoids
- □ Swallowing difficulty
- □ Black/bloody stool
- □ Constipation
- □ Diarrhea
- □ _____
- □ No complaints

Genitourinary:
- □ Vaginal complaints
- □ Urinary frequency/urgency
- □ Pregnancy
- □ Last menstrual period
- □ _____
- □ No complaints

Musculoskeletel/Extremities:
- □ Neck or back pain
- □ Joint pain/stiffness/swelling
- □ General muscle aches
- □ _____
- □ No complaints

Hematologic:
- □ Anemia, bleeding or bruising
- □ _____
- □ No complaints

Skin:
- □ Unexplained rash, itching
- □ Change in skin color
- □ Unusual mole
- □ Nipple discharge
- □ Boils
- □ Skin growths
- □ Breast pain, lump
- □ _____
- □ No complaints

Neurologic:
- □ Frequent headaches
- □ Numbness or tingling
- □ Weakness or fatigue
- □ Dizziness, syncope
- □ Difficulty walking
- □ Memory loss, speech problems
- □ _____
- □ No complaints

Infectious Disease:
- □ Contact w/ body fluids
- □ Hepatitis
- □ HIV
- □ _____
- □ None

WHEAT MEDICAL CENTER, LLC/
REGIONAL PAIN SPECIALISTS

CANCELLATION POLICY

DUE TO THE INCREASE IN FREQUENT LAST MINUTE CANCELLATIONS AND NO SHOW/MISSED APPOINTMENTS, OUR OFFICE HAS INSTITUTED A NEW POLICY WHICH NOW REQUIRES A MINIMUM OF 3 BUSINESS DAYS NOTICE FOR ANY CANCELLATIONS OR RESCHEDULING OF APPOINTMENTS.

A NON-CANCELLATION FEE FOR A REGULAR OFFICE VISIT APPOINTMENT WILL BE $25.00.

A NON-CANCELLATION FEE FOR AN APPOINTMENT FOR A PROCEDURE WILL BE $100.00.

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE ABOVE CANCELLATION POLICY AND AGREE TO THE ABOVE TERMS.

_____ _____

PATIENT SIGNATURE: DATE:

_____ _____

WITNESS SIGNATURE: DATE:

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary. ***This information is made available on request by a patient***

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW
IT CAREFULLY. ***A copy of any and all notices are available at the front desk.***

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- To run our Practice more efficiently and ensure all our patients receive quality care
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you.
These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices that follows this summary.

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Patient Acknowledgement: _____ Date: _____

Printed Name – Patient: _____

Witness – Practice Representative: _____ Date: _____

Printed Name – Practice Representative: _____

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

Name: _____ Phone: _____
Name: _____ Phone: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone: _____
Name: _____ Phone: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

Also please indicate if you wish all correspondence from our office send in a seal envelope marked "CONFIDENTIAL." □ Yes □ No

4. Please print the telephone number where you want to receive calls or texts about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

_____

or email: _____

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? YES ___ NO ___

Patient Name: _____

_____ _____
Patient Signature Date

Wheat Medical Center, LLC
138 East Fifth Street
Natchitoches, LA 71457

Patient Communication/Records Consent

To better assist us in your medical treatment this consent will allow Wheat Medical Center, LLC/Regional Pain Specialists staff to speak with your other treating physicians, attorneys, or professionals concerning your treatment. This consent will also allow us to obtain any necessary medical records to assist in your treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

WHEAT MEDICAL CENTER, LLC/
REGIONAL PAIN SPECIALISTS
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help us a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

I. **ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE:** Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes all applicable deductibles, coinsurances and copayments for participating insurance companies. **WHEAT MEDICAL CENTER, LLC** accepts payments via cash, personal checks, VISA or MasterCard. Please be advised there is a $25.00 service charge for returned checks. In the event that you have a scheduled appointment and you are not able to make payment on the day services are rendered then it will be necessary to reschedule your appointment for a later date. Patients with an outstanding balance of 60 days or more overdue must make arrangements for payment prior to scheduling any further appointments.

II. **INSURANCE:** We will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, coinsurance and copayments at the time of service. If we have not received payment from the insurance company within 45 days of the date of service, you may be expected to pay the balance in full. It is your responsibility to be sure all charges are paid whether by you or by your insurance carrier. We will bill secondary insurance companies. If you have questions, please contact our Business Office Manager **between 9:00 a.m. to 11:00 a.m. and 1:30 p.m. to 4:30 p.m., Monday through Thursday at 318-352-4477.**

III. **REFUNDS:** Patient/guarantor credits in amounts less than $20.00 will be retained on your account to be credited toward future balances unless a written request for a refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

IV. **MANAGED CARE:** If you are enrolled in a managed care insurance plan (i.e., HMO), we must receive a referral from your primary care physician before you can be seen at **Wheat Medical Center, LLC**. Any referral whether prior to treatment or a retroactive referral are not always a guarantee of payment.

V. **MISSED APPOINTMENTS/LATE CANCELLATIONS:** Missed appointments represent a cost to us, to you and to other patients who could have been seen at the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand **Wheat Medical Center, LLC** Financial Policy. I agree to assign insurance benefits to **Wheat Medical Center, LLC**. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Revised 07/2015

WHEAT MEDICAL CENTER, LLC/
REGIONAL PAIN SPECIALISTS

138 East 5th Street
Natchitoches, La. 71457

TO PROSPECTIVE PATIENTS:

WHEAT MEDICAL CENTER, LLC welcomes the opportunity to provide the highest quality medical assistance and treatment to you.

However, due to high patient volume of involvement in personal liability claims and/or lawsuits against third parties this has caused great administrative cost and burden to **WHEAT MEDICAL CENTER, LLC/REGAIONAL PAIN SPECIALISTS. WHEAT MEDICAL CENTER/REGAIONAL PAIN SPECIALISTS** does not evaluate and/or treat patients who are involved in any actual or potential litigation and/or liability claims.

WHEAT MEDICAL CENTER, LLC/REGAIONAL PAIN SPECIALISTS respectfully requests that you acknowledge the following statement in the space provided below:

> **"THERE IS NO PENDING OR PROSPECTIVE LIABILITY CLAIM AND/OR LAWSUIT ASSOCIATED WITH MY MEDICAL CONDITION(S) THAT WILL BE EVALUATED TODAY BY WHEAT MEDICAL CENTER, LLC."**

ACKNOWLEDGED AND AGREED TO THIS DATE: _____.

_____
Signature

_____
Witnessed by: (Office Staff)