WINDERMERE
Medical Center
Primary Care | Walk-in Care | Chiropractic Care

PATIENT REGISTRATION

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First Name/Last Name: ____

Date of Birth/Age: ________________________ MALE / FEMALE (Circle one)

Mailing Address: ____ City: ______________________________

State/ZIP: ________________________________

Home Phone: ___________________ Cell Phone: ___________________ Other Phone: _____________________

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

Social Security #: _______ - _____ - _______ Email address: ____

EMERGENCY CONTACT

Name: ____ Relation: ____

Contact Number: _______________________________ Address: ____

INSURANCE

Insurance: ____ Policy Number: ____

Policy Holder SSN: _______ - _____ - _______ DOB: ___________ Relation to Patient: _________________________

Secondary Insurance: _______________________________ Policy Number: ____

Policy Holder SSN: _______ - _____ - _______ DOB: ___________ Relation to Patient: _________________________

OFFICE USE ONLY

SCANNED PICTURE ID: _________ SCANNED ID/INSURANCE CARD: _________

ALL FORMS REVIEWED BY: _________

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CASE HISTORY: ____________________________ DATE: ____________________

Please answer all questions completely. Please print.

This information is confidential in nature. Your answers will help us determine your course of treatment

Occupation: _____________________________ Who referred you? ____

Employers Name: ________________________ Employers Address: _______________________________________

Spouse First Name: _________________________________Spouse SS# ____________________________________

Spouse's Employer: _______________________________ Spouse work Number: _____________________________

1. Major Complaints

____

____

____

2. Date current symptoms began? ______________ What caused symptoms? ________________________________

____

3. Pain is now ___ mild ___ moderate ___severe ___improving ___staying the same ___ worse

4. Has this happened before? ___ Yes ___ No If yes, when____

5. Does this interfere with normal daily activity? ___ Yes ___ No Family history of same condition?___ Yes___ No

6. What helps this condition? ____

7. What aggravates this condition? ____

8. Any work related accidents in the past two years? ___ Yes ___ No

9. Any automobile accidents in the past two years? ___ Yes ___ No

10. Do you smoke? ________ Are you taking any nutritional supplements? ___ Yes ___ No

11. Have you been treated for this condition by another doctor? ___ Yes ___ No

12. If yes, What doctor: ____

13. What treatment by other doctor? _______________________ Length of care? ___________________________

14. What was your diagnosis? ___________________ Were x-rays taken? ___ Yes ___ No

15. List any surgeries: ____

16. List any Fractures: ___ Yes ___ No Medications taking: ____

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Please indicate for each of the following questions below your experience by use of the following codes:

(1) Never Had (2) Previously Had (3) Presently Have

Musculoskeletal System

_____ Low back problems

_____ Pain between shoulders

_____ Neck problems

_____ Arm problems

_____ Leg problems

_____ Swollen joints

_____ Painful joints

_____ Sore muscles

_____ Weak muscles

_____ Walking problems

_____ Ruptures

_____ Broken bones

Genito-Uniary System

_____ Bladder trouble

_____ Excessive urination

_____ Scanty urination

_____ Painful urination

_____ Discolored urine

FEMALE

_____ Vaginal discharge

_____ Vaginal bleeding

_____ Vaginal pain

_____ Breast pain

_____ Lumps on breast

Are your Pregnant?
___ Yes ___ No

Gastro-Intestinal System

_____ Poor appetite

_____ Excessive hunger

_____ Difficult swallowing

_____ Excessive thirst

_____ Nausea

_____ Vomiting blood

_____ Abdominal pain

_____ Diarrhea

_____ Constipation

_____ Black stools

_____ Gall bladder problems

_____ Bloody stools

_____ Weight problems

Cardiovascular System

_____ Chest pain

_____ Pain over heart

_____ Difficult breathing

_____ Persistent cough

_____ Coughing phlegm

_____ Coughing blood

_____ Rapid heartbeat

_____ High blood pressure

_____ Heart problems

_____ Lung problems

_____ Varicose veins

Eye, Ear, Nose & Throat

_____ Eye strain

_____ Eye Inflammation

_____ Vision problems

_____ Ear pain

_____ Ear noises

_____ Ear discharge

_____ Hearing loss

_____ Nose pain

_____ Difficult breathing through nose

_____ Sore / mouth or gums

_____ Sore throat / Difficult speaking

Nervous System

_____ Numbness

_____ Loss of feeling

_____ Paralysis

_____ Dizziness

_____ Fainting

_____ Headaches

_____ Muscle jerking

_____ Convulsions

_____ Forgetfulness

_____ Confusion

_____ Depression

Patient Signature: ____________________________________ Date: ______________

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Authorization to Release or Use Information for Treatment, Payment, or Health Care Operation

I hereby authorize the releaser use of my individually identifiable health information ("protected health information", or "PHI") and medical record information by Patel Medical Ventures, LLC dba Windermere Medical Center, in order to carry out treatment, payment, or health care operations. You should review the Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such notice prior to signing this consent form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice.

You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I acknowledge and agree that the practice may disclose my PHI and medical record information to *only* the individuals I designate who are my family members, legal representatives, guardians, healthcare surrogates, or have power of attorney on my behalf (please list all applicable names).

Name: ____ Relation: _____________________________

Name: ____ Relation: _____________________________

Name: ____ Relation: _____________________________

Name: ____ Relation: _____________________________

I authorize Windermere Medical Center to contact me (and leave messages regarding appointments or other general information) via: **Email**:☐ **Home Phone**:☐ **Cell Phone**:☐ **Work Phone**:☐

OK to leave phone message with (NAME): ____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective except to the extent that the practice has already taken action based on the prior consent. The practice may refuse to treat you if you (or an authorize representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the practice is required by law to treat individuals).

Initialing below indicates that you have read and will comply with this policy, and you have read our Notice of Privacy Practices.

______ **(Patient/Parent Initials)**

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Patient Financial Policy

(INITIAL BY EACH ITEM)

Our goal at Windermere Medical Center is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our financial policy allows us to maintain a good flow of communication and run an efficient medical practice.

We verify insurance eligibility for every patient prior to their scheduled appointments and for all walk-in patients. To maintain a strong financial standing while providing excellent medical care, we have implemented a financial policy of collecting all copays, deductibles, and co-insurances **on the day** of your visit. If we find that you have overpaid, we will issue a refund once the Billing Department reviews your Explanation of Benefits (EOB). If you still have patient responsibility left over, we will send you a statement with a balance due.

If you are responsible for a deductible or co-insurance, we will collect a set fee up front for your visit:

Deductible Fee:

Walk-In Visits/Scheduled Appts
New Patients - $160
Established - $70

Co-Insurance Fee:

Walk-In Visits/Scheduled Appts
New Patients - $20
Established - $20

______ **(Patient/Parent Initials)**

SPECIAL NOTES

If you are seen in our Walk-In Clinic, and you have a ***deductible*** that has not been met, you are subject to additional fees if the following applies:

1) You have an in-office procedure (IV fluids, breathing treatment, laceration repair with sutures, splinting, additional supplies, to include crutches, x-rays, or other complex procedures)
2) You have medications administered (oral, IV, or injection)

You will be charged for these additional procedures upon checking out from your visit.
______ **(Patient/Parent Initials)**

INSURANCE – As a courtesy to our patients, we will file claims on all visits and procedures. When we file a claim on your behalf, it is with understanding that benefits will be assigned to Patel Medical Ventures, LLC dba Windermere Medical Center. You are responsible for all co-payments, deductibles, co-insurance and non-covered services. **The ultimate responsibility for understanding your insurance benefits regarding payments, preventative services, coverage for physician and lab services, pathology, radiology, and vaccination coverage rests with you.**
______ **(Patient/Parent Initials)**

AFTER HOURS - If you are seen **after 5pm during the week, or on Saturday, it is considered *after-hours***. The after-hours reimbursement billing code (99050) will be submitted for such visits. Your insurance plan may or may not cover this, and therefore, you may or may not incur patient responsibility. Once we receive the explanation of benefits (EOB) from your insurance company, our billing department will review your account to determine your responsibility and send you a statement for remittance of payment if necessary.
______ **(Patient/Parent Initials)**

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PREVENTATIVE PHYSICALS WITH LAB REVIEW OR OTHER ADDRESSED ISSUES/CONCERNS – While your physical exam (preventative/wellness exam) may be covered by your insurance plan, the ***lab review*** component of the visit, or other acute complaints or medication refills addressed during the exam are not considered preventative and will be billed as such. This portion of your visit may or may not be covered by your insurance, and you will be responsible for any remaining balance applied by your insurance company.
_____ (INITIALS)

AFTER HOURS PREVENTATIVE PHYSICALS – Preventative physicals (wellness visits for adults **or** children) scheduled between 5pm and 9pm, Monday – Friday, or on Saturdays, will be charged an After-Hours Visit Fee of **$25**. This is due to your insurance not covering the after-hours component of a preventative visit. To avoid this fee, you should schedule your preventative appointments before 5pm, Monday – Friday.
_____ (**Patient/Parent Initials**)

CASH PAYMENTS – Payments of **$25 or less** are cash only. Please note the following:

*We will not accept credit or debit card payments for **$1.00, $2.00, or $5.00** payments.

*ACCEPTED TYPES OF PAYMENT: Cash, Visa, MasterCard, and Discover. **NO PERSONAL** or **BUSINESS CHECKS** will be accepted.

_____ (**Patient/Parent Initials**)

LAB FEES – If your provider orders labs, you are welcome to visit a LabCorp, Quest, or Vista patient service center (PSC). We do offer you the convenience of having your labs drawn at WMC; a lab draw/convenience fee of $15 will be collected for **physical exams, your initial visit, or any follow-up visit**. **This includes labs drawn during a walk-in visit.** Your lab specimen(s) will be sent to LabCorp, Quest, or Vista, based on your insurance, or if you are a self-pay patient. Please note the following:

***Self-pay patients:** If you choose to have your labs drawn in the office, you will pay for your labs on the day of your visit. The lab draw fee is included in the charge for your labs.

*All lab draw fees are $15 and **CASH ONLY**.

_____ (**Patient/Parent Initials**)

NEW PATIENTS – New patients are responsible for co-payments/co-insurances/self-pay fees up front. Payment arrangements for first visits are not authorized.
_____ (**Patient/Parent Initials**)

LATE APPOINTMENT & CANCELLATION POLICY – We ask all patients to be courteous of the provider and staff's time and attention for your scheduled appointment. If you arrive late (or call to notify the office that you will be late) ***more than 35 minutes***, your appointment will be cancelled/rescheduled and you will be charged a $25 cancellation fee (same applies for specialty appointments – Imaging appointments will incur a **$50** cancellation fee). If you arrive late, but *before* the 35 minutes, you may still be seen, but other patients showing on time for their appointment will be seen first.
_____ (Patient/Parent Initials)

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APPOINTMENT REMINDER & CANCELLATION POLICY & FEES – We provide our patients with two forms of appointment reminders: email and text messages. **It is your responsibility to confirm your appointment.**

1. You will receive an email reminder from **HFAlerts@nextgen.com** (and text message, if you do not confirm through the email) 7 days before your appointment. You must click on "Confirm Your Appointment" in the email, or tap on the link in your text message (example: Please confirm: https://goo.gl/r57lRv - this link will open the browser on your phone – click on "Confirm My Appointment"). NOTE: Do not reply to the text message, as our system is not programmed to receive incoming text messages.
2. If your appointment is not confirmed with one of these two reminders, one more email and text message will be sent to you 3 days before your appointment.
3. If you do not confirm your appointment at that time, we will call you **2 days** before your appointment. If you do not confirm your appointment by **12pm**, *2 days before the appointment*, your appointment will be cancelled and you will be charged a **$25 cancellation fee**, and your appointment slot will be filled with another patient's appointment. If you *call* and cancel within 48 hours, you will be charged a **$25 cancellation fee**.

______ **(Patient/Parent Initials)**

Patients who cancel (less than 48 hours' notice) for an ***in-office procedure*** (**echocardiogram or ultrasound**) will be charged **$50**.
______ **(Patient/Parent Initials)**

NO SHOW FEE – Patients who do not show for a ***scheduled appointment*** will be charged a no-show fee of **$40**. Patients who do not show for an ***in-office procedure*** (**echocardiogram or ultrasound**) will be charged **$75**.
______ **(Patient/Parent Initials)**

NON-COVERED SERVICES – Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and medically necessary". If Medicare or another insurance determines that your visit with our physician or nurse practitioner is not "reasonable and medically necessary", they will deny payment for that service. You will be responsible for anything not covered by Medicare or your insurance company. All labs are submitted based on **appropriate codes** to a lab based on one's medical condition.
______ **(Patient/Parent Initials)**

PAST DUE ACCOUNTS – Unpaid balances must be resolved **prior** to being seen in the office. If necessary, you may discuss payment arrangements with the Practice Administrator or Billing Manager. If your account is 90 days past due, your account is subject to collections from a third-party collection agency.
______ **(Patient/Parent Initials)**

ADMINISTRATIVE FEES

Windermere Medical Center prides itself on providing excellent medical care and customer service to you and your family. We can also provide administrative services to patients upon request. If you require a specific form, paperwork, or letter for your employer or other reasons, we will charge an administrative fee based on the request. Fees must be paid in full before the letter or administrative service is completed. You must allow 7 days for any form(s) to be completed. You will be notified when your letter or paperwork is complete and ready for pick-up at the front desk.

1. Letter typed and printed on company letterhead, and signed by the physician or other provider (example: special travel arrangements, requirements for service or emotional support animals, work accommodations, etc.): **$25**
2. Forms or paperwork for work accommodations (not FMLA), handicap parking placards: **$25**
3. Family Medical Leave Act (FMLA): this requires a face-to-face encounter/appointment with a physician. You will be charged your normal office visit fee, and an **additional $50** to complete the FMLA packet.
4. Disability (Short or Long Term): you must be an established patient for at least one year *with* a physical before disability forms are completed: **$50**
5. Requests for admission into a nursing home or assisted living facility: you must be an established patient for ***at least one year*** with a physical: **$50**

______ **(Patient/Parent Initials)**

Prescription Refill and Controlled Substances Policy

(INITIAL BY EACH ITEM)

Our goal at Windermere Medical Center is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our Prescription Refill and Controlled Substances Policy allows us to maintain a good flow of communication and run an efficient medical practice. Because we are a new practice, we must establish a solid medical history for each of our patients, thus requiring a specific policy for patients who require regular refills for medications, and for patients requesting a controlled substance prescription.

Windermere Medical Center has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility to comply with our Prescription Refill and Controlled Substances Policy.

Please read this policy in full. Your initials and signature indicate that you agree with and will comply with our policy.

1. All new patients must establish with a Windermere Medical Center provider prior to having a prescription refilled.
   ______ **(Patient/Parent Initials)**
2. Additional lab tests may be required to determine exact dosages of prescribed medications; your insurance may or may not cover these tests. It is your responsibility to check with your insurance company to determine what they will cover.
   ______ **(Patient/Parent Initials)**
3. If your prescription is a *regular* medication (prescribed for an ongoing period of time, requiring multiple refills), you *must* be seen by a Windermere Medical Center provider **<u>every three months</u>** (or more frequent if necessary) to have your prescription refilled. This will be considered a regular office visit and billed accordingly.
   ______ **(Patient/Parent Initials)**
4. All patients on any prescription medications are required, at a minimum, to follow up twice a year (every 6 months) for blood work and an appointment for your medication refill. Chronic conditions such as hypertension, diabetes, high cholesterol, thyroid disease, depression, or other conditions will require a follow-up appointment every 3 months (at the discretion of the physician).
   ______ **(Patient/Parent Initials)**

5. **If you are due for a refill on your prescription, you must call your *pharmacy* to request a refill; they will fax a refill request to our office. This must be done within 5 days of your medication running out. Refills will *not* be granted unless you follow this protocol.**
   ______ **(Patient/Parent Initials)**

PRIOR AUTHORIZATIONS FOR MEDICATIONS

1. We will make every effort to ensure that you receive the safest, most effective, and reasonably priced prescription drugs that are best suited for your healthcare. We also abide by regulations set by insurance companies and government agencies. Many health insurance companies or plans are requiring Prior Authorization or approval for your medication.
2. This is an additional and labor-intensive service our medical staff completes; we will charge an administrative fee of **$50 per authorization**. This cost is an out-of-pocket expense to you and is **not covered** by insurance.
   ______ **(Patient/Parent Initials)**

CONTROLLED SUBSTANCES

1. Controlled substances (pain, sleep, muscle relaxants, stimulants, testosterone/hormone replacement) are tracked by the State of Florida Prescription Drug Monitoring Program (PDMP). Pharmacies and physicians can track your usage of controlled substances through obtaining an online report, which annotates physicians who have prescribed, and pharmacies who have dispensed these medications.
   ______ **(Patient/Parent Initials)**
2. New patients who request a controlled substance for acute pain may receive **one** prescription of pain medication or controlled substance (at the discretion of the physician) after a PDMP report is obtained.
   ______ **(Patient/Parent Initials)**
3. Windermere Medical Center physicians **do not refill narcotic medication prescriptions on an ongoing basis**. If you require such medications, you will be referred to a pain management specialist or other specialist related to your condition.
   ______ **(Patient/Parent Initials)**
4. If the physicians at WMC are dispensing a controlled substance (non-narcotic pain medication, sleep medication, muscle relaxant, ADHD medications, testosterone, or hormone replacement), **you are required to have a face-to-face encounter every 3 months for prescription refills.**
   ______ **(Patient/Parent Initials)**

Failure to comply with this our Prescription Refill and Controlled Substance Policy will result in dismissal from Windermere Medical Center.
______ **(Patient/Parent Initials)**

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Marketplace/ObamaCare Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder portion of your health insurance premium.

If you purchased your health insurance through the ObamaCare website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at Windermere Medical Center. Your account will be placed in a self-pay status until your premiums payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with Windermere Medical Center will remain in a self-pay status.

If your balance with Windermere Medical Center is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay Windermere Medical Center in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ObamaCare (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

______________________________________ ____________________

Patient Name/Signature Date

I confirm that I **have** purchased insurance through ObamaCare at www.healthcare.gov; I will comply with this policy regarding my account.

______________________________________ ____________________

Patient Name/Signature Date