WellMed

PATIENT REGISTRATION

Patient name: _____ Birth date (Month/Day/Year): _____

Sex: ☐ M ☐ F ☐ Other Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Street address: _____

City/State/Zip: _____

Email address: _____

WellMed recommends that you provide a private email address to which only you have access. For information on the WellMed Privacy Policy, please refer to www.wellmedhealthcare.com/privacy/.

Tel. no.: Work: _____ Home: _____ Cell: _____

Caregiver name: _____ Phone: _____

How would you like to receive information? ☐ Mail ☐ Phone ☐ Text Cell No. _____

Patient's preferred spoken medical language: ☐ English ☐ Spanish ☐ Other _____

Patient's preferred written medical language: ☐ English ☐ Spanish ☐ Other _____

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

Do you require interpretation (verbal) services? Yes ☐ No ☐ Language: _____

Do you ever need help understanding the medical information you receive from your provider or the clinic staff? Yes ☐ No ☐

Is the person you go to for understanding of medical information (i.e., a caregiver) on your HIPAA list? Yes ☐ No ☐

Race: ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White
☐ American Indian or Alaska Native ☐ Prefer not to report

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

Are you a WellMed employee? Yes ☐ No ☐

Are you a family member of a WellMed employee? Yes ☐ No ☐

I heard about WellMed through a/an: ☐ Current patient ☐ Family/Friend ☐ Clinic Event ☐ Advertisement
☐ Health plan and/or Representative ☐ Community event ☐ Unavailable/Unknown ☐ Other: _____

WellMed does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call 888-781-WELL (9355). ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888-781-WELL (9355). 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888-781-WELL (9355)。

ATTACH COPIES: INSURANCE CARD/DRIVER'S LICENSE

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship to patient: _____

Tel. no.: Work: _____ Home: _____ Cell: _____

INSURANCE

Employer name: _____

Employer address/Work No.: _____

Patients occupation: _____

Do you have military healthcare benefits? ☐ Yes ☐ No

#1 Insurance Co. name: _____ ID#: _____

Plan: _____ Group: _____

Insured's name: _____ Relationship to patient: _____

Insured's employer: _____

Primary care physician/Phone no.: _____

#2 Insurance Co. name: _____ ID#: _____

Plan: _____ Group: _____

Insured's name: _____ Relationship to patient: _____

Insured's employer: _____

Primary care physician/Phone no.: _____

AUTHORIZATION TO RECEIVE HISTORICAL PRESCRIPTION HISTORY

I hereby authorize WellMed and its Affiliated Providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand that WellMed and its Affiliated Providers will use my external prescription history to provide me with medical treatment and to evaluate and improve patient safety and the quality of medical care provided to me. I understand that I can revoke my permission at any time by giving written notice to my provider.

Signature of patient or legal representative: _____ Date: _____

PHARMACY INFORMATION

Preferred mail order pharmacy: _____

Address: _____

Phone: _____

Preferred local pharmacy: _____

Address: _____

Phone: _____

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ASSIGNMENT OF BENEFITS

I hereby authorize WellMed to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to WellMed.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

Signature of patient or legal representative:_____ Date: _____

CONSENT TO TREAT

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means:

_____ (name of patient).

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at WellMed and their designated associates or assistants believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurse practitioners, physician assistants, nurses, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

Signature of patient or legal representative:_____ Date: _____

CONSENT FOR DIGITAL COMMUNICATIONS

By providing my telephone number to WellMed on this Patient Registration Form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from WellMed and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing.

Appointment reminders and notification program: I agree to receive text message appointment reminders and clinic-related notifications, such as flu shot availability or closures, on the phone number provided on this Patient Registration Form. I understand that message and data rates may apply, terms and privacy information are available at www.wellmedhealthcare.com/texting-terms/, and that messages will be recurring. I also acknowledge and agree that these text messages, which may contain Protected Health Information (PHI), will be sent by unencrypted means and there is some risk of disclosure or interception of the messages.

Signature of patient or legal representative:_____ Date: _____

CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS

I consent to have my image taken by WellMed for use of treatment, payment, or for health care operations. I understand that my image, including photographs, etc. will be for the purpose of assisting in my care, payment or health care operations including quality initiatives.

I understand that WellMed will own these images; however copies of them may be available at a reasonable cost. 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.

I certify this form has been fully explained to me and I understand its contents.

Signature of patient or legal representative:_____ Date: _____

Employer:_____

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