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: _____

ATTACH COPIES: INSURANCE CARD/DRIVER'S LICENSE

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:_____

ATTACH COPIES: INSURANCE CARD/DRIVER'S LICENSE

WellMed

PAYMENT POLICY TO OUR PATIENTS

Thank you for choosing WellMed as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our payment policy below and sign in the space provided. We are happy to answer any questions you may have. A copy will be provided to you upon request.

Payment: If your deductible has not been met, or a percentage is your responsibility, payment is expected at the time of service. You are also responsible for any balance due after insurance processes your claim. The balance will be balance billed via a statement. There is a $25 charge for returned checks.

Proof of insurance: All patients must complete the patient information form before seeing a clinician. Please notify our office of insurance changes in primary or secondary insurance coverage. We will obtain a copy of your driver's license or state ID and current, valid insurance card. If you do not provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. If we are unable to verify/confirm your eligibility, you may be responsible for incurred charges.

Insurance: WellMed participates in various insurance plans, including Medicare. Before receiving services, you should know your benefits and verify that we are participating providers for your insurance. If you receive service and we are not participating providers or our physician is not listed as your primary care provider with your insurance company, payment is due in full at the time of service.

Managed care: All managed care (HMO, PPO, etc.) co-payments are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as out of network or non-covered treatment, and you will be responsible for a larger amount or all of the charges. Please ensure you understand what services are covered and are prepared to pay for any service deemed to be non-covered or not authorized by the plan.

Medicare: WellMed participates with the Medicare program and accepts the Medicare allowable payment, patient deductible, and/or 20% co-insurance. If you have supplemental insurance (Medigap) please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. In these cases, you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

Medicaid: If you have Medicaid coverage of any kind, please notify us prior to your visit. This is part of your agreement with Medicaid; failure to notify us of Medicaid coverage may result in your financial responsibility for services rendered.

Co-payments and deductibles: All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or considered non-reasonable or not necessary by Medicare or other insurers. A payment is due at the time of service and any remaining balance due will be billed via a statement.

Claims submission: We will submit your claims to your Insurance. Your insurance 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.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-payment: If your account is past due you may contact our billing department to make payment arrangements.

Continued on next page →

WellMed®

PAYMENT POLICY TO OUR PATIENTS

Automobile accident patients: WellMed may treat established patients for automobile accident care. A claim will be filed with your health insurance plan, or we accept payment as self-pay. WellMed will not accept a letter of protection from an attorney as a guarantee of payment or bill third-party insurance.

Workers' Compensation: WellMed does not treat new or established patients for workers' compensation/work injury. Additionally, WellMed does not participate in workers' compensation insurances.

Children of divorced parents: Payment for treatment of minor children of divorced parents rests with the parent who seeks the treatment. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of WellMed.

Fee schedule (charges): Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Statements: We will send a billing statement to the billing address you provide. If you have any questions or dispute the validity of the balance, please contact our business office within 30 days of receipt of the statement.

Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient DOB

_____ _____

Signature of patient or responsible party Date

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION WITHIN WELLMED

Patient's full name _____ Date of Birth _____ Member or Subscriber ID # _____

Patient's street address _____ City _____ State _____ Zip code _____

I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by others, including health care providers. It may include medical, pharmacy, dental, vision, behavioral health, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information.
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form.
- The information I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws.
- This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying WellMed in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

I authorize **WellMed and its affiliates** to access, use and disclose my individually identifiable health information between themselves.

I also authorize **my treating providers (past, present and future), to access, use and disclose my individually identifiable health information with WellMed and its affiliates.**

Treating provider(s) - check all that apply:*

☐ All providers with a confirmed treating relationship including WellMed contracted or affiliated providers

☐ These specific provider(s)_____

_____

* I understand that consistent with 42 CFR Part 2, I have a right upon my request to be provided a list of entities to which my information has been disclosed pursuant to this general designation.

Health information to be us□d□disclosed □□d s□□r□d□
(Select one option)

☐ I authorize these entities to access, use and disclose all of my health information including medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include, for example information relating to visits, admissions, treatment, claims, case management or care coordination□**or**

☐ I authorize only the disclosure of the following information:

_____
(Type of Information)

CONTINUED ON NEXT PAGE

Purpose of Disclosure:
(Select one option)

☐ My health information is being disclosed to provide me with better treatment, payment facilitation, care coordination and/or case management; or

☐ My health information is being disclosed for the following purpose(s) only (examples include claims management or payment, eligibility and benefits, disability management, etc.):

_____

(Explain Purpose)

Format: (unless another format is mutually agreed upon between my provider and designee):

☐ An electronic record

☐ Hard copy

_____ _____

Signature of Individual Date

If the person signing the form is not the patient, provide full name, relationship to patient, phone number and address:

_____ _____ _____

Name Relationship Phone

_____ _____ _____ _____

Street address City State Zip code

Please Note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient.

(For general designations related to release of substance use disorder information only (e.g., all past, present and future treating providers)) I understand that I may request of list of entities to which my information has been disclosed.

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD

WellMed

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION TO HEALTH INFORMATION EXCHANGES (HIEs) AND INTEROPERABILITY EXCHANGES

Patient's full name | Date of Birth | Member or Subscriber ID #

Patient's street address | City | State | Zip code

I understand and agree that:

- This authorization is voluntary and I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not sign this form;
- Greater Houston Healthconnect, Carequality, Commonwell* and any future HIEs to which WellMed connects and their current and future participants may access, use, and disclose my Protected Health Information (PHI) electronically through the exchanges for the purposes of treatment, payment, and health care operations;
- These entities may connect to other HIEs in Texas and across the country and I authorize these entities to access, use, and disclose my information with those exchanges for the same treatment, payment, and health care operation purposes;
- My PHI, including notes, test results, lab reports, x-rays, medication lists, or any other relevant electronic PHI may be shared through these exchanges;
- My PHI may be subject to re-disclosure by the recipient entities and if those recipients are not health care providers or health plans, the information may no longer be protected by the federal privacy regulations; and
- This authorization remains in effect unless and until I revoke it. I may revoke this authorization at any time by giving written notice to WellMed. I understand that revoking this authorization will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Individual | Date

If the person signing the form is not the patient, provide full name, relationship to patient, phone number and address:

Name | Relationship | Phone

Street address | City | State | Zip code

Please Note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD

*A detailed description of these exchange entities is included on page 4 of this form.

CONTINUED ON NEXT PAGE

*Greater Houston Healthconnect is a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your PHI. A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information – it allows your information to be shared in a new way. All Health connect participants must protect your privacy in accordance with state and federal laws.

Carequality, Inc. is a 501(c)(3) non-profit and a national-level, consensus-built, interoperability framework to enable exchange between and among health information networks and service platforms. Carequality supports secure access to health information across diverse networks, including those operated by electronic health record vendors, record locator service providers, health information exchanges, and others. The connectivity is governed by technical and policy agreements developed and maintained by a broad group of industry and government stakeholders.

Commonwell provides participating practitioners access to past and present medical information to make better decisions and better coordinate care across your care teams. To view participating provider sites, visit the Commonwell website at www.commonwellalliance.org/providers.

INFORMED CONSENT FOR TELEHEALTH/TELEMEDICINE

Date:_____

Patient name:_____ Date of birth:_____

I understand that I have the following rights with respect to telehealth/telemedicine:

1. Definition of telehealth/telemedicine. Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

2. Right to care. I understand that the same standard of care that applies to an in-person visit will apply to a video visit. I understand that I have the right not to participate or decide to stop participating in a video visit and that my refusal will not affect my right to future care or treatment.

3. Patient information & confidentiality. I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that video, audio, or photographs may be stored with my consent, and that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

4. Communication risk & consent. I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined, that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. By signing this form (including all forms of digital signature) and providing my mobile number and/or email address, within the telehealth platform, I consent to receive SMS/text messages or emails (message and data rates may apply) for the purpose of video visit reminders and/or connection links. I acknowledge that messages may contain protected health information (PHI) and sent via unencrypted means, there is some risk of disclosure or interception, and I may opt out by removing my mobile number or email address from the applicable account within the telehealth platform. I acknowledge understanding of the Texting Terms and Conditions available at www.wellmedhealthcare.com/texting-terms.

5. Insurance & Billing. I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my video visit. I understand that health plan payment policies for video visits may differ from in-person visits.

6. Complaints. I understand that I may file a complaint about physicians, as well as other licensees and registrants of the Texas Medical Board by contacting 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, TX 78768-2018 (attn.: Investigations) or 1-800-201-9353, and more information can be found at www.tmb.state.tx.us.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I understand that I may revoke my consent at any time by contacting my WellMed clinic.

Patient signature:_____ Date:_____

On behalf of patient (family member or caregiver) signature: _____ Date:_____

Please note: A guardian or court appointed representative must attach a copy of legal authorization to represent the member.

Form is maintained in patient's medical record.

AUTHORIZATION TO WEB-ENABLE FOR THE WELLMED PATIENT PORTAL

I hereby authorize WellMed and Its Affiliated Providers to electronically send communications to me or my Proxy (individual that I authorize to have access to my medical record information) via the WellMed Patient Portal at the e-mail address provided below. If I assign a Proxy for the WellMed Patient Portal, I understand that this individual shall have access to my medical record information. I have assigned this individual access under the Health Insurance Portability and Accountability Act (HIPAA) and have a current signed authorization to release information in my medical file granting access to this individual with an identified expiration date. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from WellMed should I decide against using the patient portal. I understand that it is my responsibility to notify WellMed if there is a change in my email account or I feel that my secure password has been breached. I understand that I can revoke my permission at any time by giving written notice to my provider. Further, I understand that online communications should never be used for emergency communications or urgent requests and that if I have an emergency or an urgent request, I should contact my physician via telephone or call □-□-□ if there is a life threatening emergency. I agree not to hold WellMed, its provider practices, providers, or any of its staff liable for network infractions beyond its control.

Patient□s Name (Please Print) _____ Patient□s Date of Birth _____

Patient□s Email Address _____

Patient□s Signature _____ Date _____

Proxy□s Name (Please Print) _____ Relationship to Patient _____

Proxy□s Email Address _____

Proxy□s Signature _____ Date _____

❑ **HIPAAVERIFIED: PRO□□ IS LISTED**