Whole Health weight Loss Institute

Crystine Lee, M.D. and Scott Perryman, M.D.

Información de Paciente	
Paciente Nombre Primero:	Middle Initial:
Paciente Apellido:	Fecha de Nacimiento:
Dirección:	Sexo:
Numero de teléfono:	Etnicidad: Raza:
Correo Electrónico:	SSN:
Nombre de Farmacia:	Numero de Farmacia:
Medico de Referencia:	Como se entero de nosotros?
Contacto de Emergencia	
Nombre:	Relación:
Numero de teléfono:	
Información de seguranza	
Por favor proporcione su tarjeta de seguro a la recepcionista. Si la persona responsable de la factura **NO** es la misma que la persona mencionada anteriormente, complete los campos a continuación.	
Nombre Completo	Fecha de Nacimiento
Compañía de seguranza:	SSN:
# ID de suscriptor	# Grupo:
Relación a paciente:	
Firma y autorización	
Verifico que la información anterior es verdadera a mi leal saber y entender. Entiendo que el pago, la prueba del seguro y / o el copago se deben hacer al momento del servicio. Autorizo a Medicare o a mi compañía de seguros a divulgar cualquier información requerida para procesar mis reclamos y pagar los servicios cubiertos prestados. Entiendo que soy financieramente responsable por cualquier saldo adeudado.	
Firma:	Fecha:

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Autorizacion para divulger informacion medica

Nombre de paciente	**Fecha de Nacimiento**
Dirrecion	
Numero de telefono	**Last 4 Digits of SSN:** XXX – XX -

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information	
Address	
Phone Number	**Fax Number**

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following persons or organizations:

Whole Health Weight Loss Institute
Phone: (707) 721-3500
Fax: (707) 721-3499

The following health information that relates to service beginning from _______________ to _______________,
may be released:

☐ Complete Records	☐ History & Physical	☐ Progress Notes	☐ Care Plan
☐ Pathology Reports	☐ Lab Reports	☐ Radiology Reports	☐ Hospital Reports
☐ Medication List	☐ Treatment Record	☐ Operation Reports	

☐ Other (please specify):

- The above person/organization receiving my medical information, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of providing care or receiving payment for said care.
- This authorization is valid for __ONE YEAR__ following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.
- By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.
- I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

____

Firma de Paciente **Nombre de Paciente** Fecha

We welcome you to our practice and thank you for the opportunity to care for you. To avoid any misunderstanding, please acknowledge your acceptance and understanding of our policies by initialing after each statement below.

Advanced Beneficiary Notice

We expect that there may be times when your insurance company will deem certain services to not be a covered benefit of your policy. supplies. If your insurance company denies these items, we ask that you acknowledge this and agree to be financially responsible:

I understand that my insurance carrier may decide to deny certain services as "not a covered benefit of my policy." Prior to these services being provided I will be given the cost of these items, and I will decide whether I wish to have them or not. In the event that I choose to have these services/items, I agree to be responsible for payment to this practice. I understand that I can appeal my insurance company's decision to deny payment.

_________(iniciales)

Waiver of Benefits

I hereby authorize WHWL (Drs. Lee and Perryman) to release information acquired during the course of my examination and treatment to the Centers for Medicare and Medicaid Services (CMS) and its agents or any other third party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of benefits directly to the medical practice of Drs. Lee and Perryman.

_________(iniciales)

Co-payment

Co-payment is due at the time of service. Due to increased administrative costs, I hereby agree to a charge of $25.00 for a processing fee if I do not pay my copayment at the time of service, or if I have not provided correct insurance information, or if my check does not clear the bank for any reason.

_________(iniciales)

Cita Perdida

Time reserved for your doctor's appointment is important. We value you as a patient and make that time for your health needs and concerns. Not showing up for your appointment or failing to notify the office at least 24 hours in advance if you need to cancel, means that we are unable to utilize that time to see other patients. I understand and agree that I will be responsible for a missed appointment fee of $150 for an initial consultation, $75 for a follow-up, and $250 for a surgery/procedure, if I fail to show up for my appointment or give cancellation notice of less than 24 hours prior to the scheduled time.

_________(iniciales)

Nombre (impreso):____Fecha:____________

Firma:____

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Missed Appointments

Credit Card Authorization Form

Card Holder Name____

Address (where statement is mailed)____________________________________

____

Type of card:

Visa ( ) Mastercard ( ) Discover ( ) American Express ( )

Credit Card Number:____

Expiration Date:___________________________

Security Code:____________________________ (on the back, except Amex on the front)

I hereby agree that the above credit card information will be utilized in the event that I fail to show for an appointment, or do not give the required 24 hour cancellation policy. The fee for a missed initial consultation is $150, the fee for a missed follow-up appointment is $75 and the fee for a missed surgery/or procedure is $250.

Signed Date