Washington Medical Group, P.C.

Patient Registration Form

Please fill out ALL Fields If not applicable, write N/A

LAST NAME	FIRST NAME	INITIAL
ADDRESS	CITY/STATE/ZIP	
HOME PHONE #	WORK PHONE #	
EMAIL ADDRESS	CELL PHONE #	
MESSAGES ABOUT ACCOUNT BALANCES AND FUTURE APPOINTMENTS WILL BE LEFT ON THE CONTACT INFORMATION PROVIDED ABOVE		
DATE OF BIRTH	MALE[ ] FEMALE[ ]	MARITAL STATUS
SOCIAL SECURITY NUMBER	REFERRING DOCTOR	
EMPLOYMENT (Check One) FULL TIME [ ]	PART TIME [ ]	STUDENT [ ]
EMPLOYER	PHONE	
ADDRESS	CITY/STATE/ZIP	
INSURANCE INFORMATION: INSURANCE CARD MUST BE PRESENTED AT TIME OF CHECK IN		
PRIMARY INSURANCE NAME		
NAME OF POLICY HOLDER	RELATIONSHIP OF PATIENT TO THE INSURED	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
INS ADDRESS	CITY, STATE, ZIP	
INSURED'S ID #	GROUP #	EFFECTIVE DATES
SECONDARY INSURANCE NAME		
NAME OF POLICY HOLDER	RELATIONSHIP OF PATIENT TO THE INSURED	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
INS ADDRESS	CITY, STATE, ZIP	
INSURED'S ID #	GROUP #	EFFECTIVE DATES
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?		PHONE #
WORKERS' COMPENSATION/PERSONAL INJURY INFORMATION		
ATTORNEY NAME	ATTORNEY PHONE	
WERE YOU HURT AT WORK?	Y N DATE OF INJURY	
HAVE YOU FILED A CLAIM	Y N	
WORKERS' COMPENSATION CLAIM #	ADJUSTERS NAME	
ADJUSTERS PHONE	ADJUSTERS ADDRESS	CITY, STATE, ZIP

Our staff is trained to inform you of the financial policies of this office.

- Payment is due at the time of service. If payment is not paid at time of service, a $10 billing fee will be applied
- Appointments for regular care that are not canceled at least 48 hours before the scheduled appointment during hours of operations are subject to a $40 "NO SHOW FEE".
- Appointments for Functional Capacity Exams that are not cancelled at least 48 hours before the scheduled appointment during hours of operations are subject to a $200 "NO SHOW FEE"
- Appointments for Neuro-Psychological Tests that are not cancelled at least 48 hours before the scheduled appointment during hours of operations are subject to a $500 "NO SHOW FEE"
- Appointments for Psychotherapy that are not canceled at least 48 hours before the scheduled appointment during hours of operations are subject to a $50 "NO SHOW FEE".
- We accept payment in the form of cash and check (*).
- I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits or non-payment.
- In the event it is necessary to refer your account to an attorney for collections, you will be responsible for all charges accrued; i.e. attorney's fees, court costs, expenses, etc.

** Check Writing Policy: No check will be honored without driver's license. All returned checks are subjected to a return check fee of $40*

I am aware that obtaining test results require a face-to-face consult with a licensed medical professional. Test results cannot be given over the phone, email and/or via facsimile. These regulations are in compliance with appropriate medical care guidelines and other government agencies within the District of Columbia. _____Initials

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (SEAL)

_____

DATE

1/1/2013

Washington Medical Group, P.C.

FINANCIAL RESPONSIBILITY AGREEMENT

I accept full financial responsibility for medical expenses incurred at the **Washington Medical Group, P.C.** if I fail to provide these provisions:

- For not providing a current physical insurance card issued by my insurance carrier and a government issued unexpired picture ID. Temporary cards, internet printouts, or copy of insurance cards are not acceptable.
- For not providing a valid referral or obtaining any required pre-authorization at the time of service.

Furthermore, I accept full financial responsibility for medical expenses incurred at the **Washington Medical Group, P.C.** for all claims denied by my insurance company or outside payer:

- For a diagnosis not covered by my insurance company (i.e. a pre-existing conditions, diagnosis of alopecia, which are excluded).
- For services provided that are not covered by my insurance plan or services they consider bundled, incidental, or mutually exclusive.
- For not volunteering accurate information that may have changed since my last visit.
- If I fail to provide written information required by my insurance company in order to file a claim for my office visits such as: E/M, checkups, etc.
- If my insurance fails to cover check-ups or "well" visits.
- If my insurance stops coverage at a set number of visits, i.e. I have a maximum of 12 visits per year for Chiropractic visits and I exceeded their allocated amount.
- For psychology treatment that requires a treatment plan by a psychiatrist prior to designated services.
- Or for services that are not adjudicated or paid by my insurance carrier within the 45 day timeframe after submission of my claim.

I understand that I am responsible for the following possible charges:

- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for regular care that I am unable to show up for, a $40.00 fee will be assessed.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for a Functional Capacity Examination, a $200.00 fee will be assessed.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for a Neuro-Psychological Test, a $500 fee will be assessed.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for a Psychological Test, a $200 fee will be assessed.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for Psychotherapy that I am unable to show up for, a $50.00 fee will be assessed. Also, if I missed two (2) consecutive appointments, I will not be allowed to pre-schedule future appointments.
- If I fail to call and cancel/re-schedule at least 48 business hours prior to any scheduled appointment for a Group Therapy, a $50 fee will be assessed.
- All payment for services rendered are due at time of service; if they are not paid, a $10.00 billing fee will be assessed to your account.
- If payments are not received within thirty (30) days of the original billing, a $10.00 re-billing fee will be assessed.
- Any checks returned from my financial institution will have a $40.00 fee assessed.
- A late fee of $15.00 will be assessed every 90 days after the initial billing date and will be assessed an 18% APR fee every 90 days after the initial billing date.
- These amounts must be paid in full prior to any further service provided by our office.

_____

Patient's Initial (Seal)

I understand that **Washington Medical Group, P.C.** is not responsible for knowing my insurance benefit plan. I am responsible for reviewing and understanding my insurance benefits information. I understand that providing proof of my insurance company eligibility does not hold **Washington Medical Group, P.C.** responsible for verifying this information.

It is my responsibility to inform **Washington Medical Group, P.C.** if I am working with a third party payer in reference to my condition i.e. workers' compensation and legal counsel. Failure to do so prior to service being rendered will cause all costs associated with my care to be my personal responsibility.

If claims filed by **Washington Medical Group, P.C.** to my insurance company or any other third party are denied, I will cooperate with the billing department of **Washington Medical Group, P.C.** to ensure payment for my services. I understand that I will be legally responsible for all costs associated with the collection of my account, including collection fees, if I default on this agreement.

Signature (Seal)

Witness Signature

Print Name

Date

Primary Insurance

Plan Insurance Address

Washington Medical Group, P.C.

NOTICE OF PRIVACY PRACTICES

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Information

We use health information about your treatment, to obtain payment and for health care operations; including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with the medical treatment or services. For example, nurses, physicians and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations including proper administration of records, evaluation of the quality of treatment and to asses the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or to other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons even without your consent. Subject to certain requirements, we are permitted to give out health information without permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious Threats to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public and/or other persons.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers' Compensations: We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses of your health information. We are not required to agree to such restrictions, but, if we do agree, we must abide by such restrictions.

Confidential Communication: You may ask us to communicate with you confidentially; for example, sending notices to separate addresses or refraining from leaving voice messages about upcoming appointments.

Inspect and Obtain Copies: In most cases, you have the right to inspect at or receive a copy of your health information. There may be a charge for copies.

Amend Information: If you believe that information in your record is incorrect or of critical information is missing, you have the right to request that we correct the existing record or add missing information.

Accounting and Disclosure: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. For more information about our privacy practices, contact the practice Operations Manager.

Complaints

If you are concerned that we have violated your privacy rights or if you disagree with a decision we have made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate contact information upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests or complaints, please contact:

Operations Manager
1327 18th Street NW
Washington, DC 20036

I, _____
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

Staff Witness seeking acknowledgment was:

Signature: _____

Date: _____

ALL PATIENTS FILL OUT PRIOR TO VISIT:

Please fill in all Fields If they do not Apply Mark N/A

WORKERS' COMPENSATION

Is your visit related to employment? Yes_____ No_____

If yes, what state? _____

Date of Accident _____

Location of Injury _____

Name of Employer _____

Address _____

_____

Contact Person/Supervisor _____

Phone Number _____

Workers' Compensation Insurance Carrier _____

Address _____

_____

Claims Adjuster _____

Phone Number _____

Claim Number _____

AUTO ACCIDENT

Is your visit related to an auto accident? Yes_____ No_____

If yes, which state _____

Date of Accident _____

Auto Insurance/Personal Injury Protection Information _____

_____

Name of Attorney _____

Address _____

Phone Number _____

Name of Adjuster _____

Claim Number _____

Phone Number _____

_____

Patient's Initials ⟸

WASHINGTON MEDICAL GROUP, P.C.

Disclosure Authorization Form

I, _____, hereby **PERMIT** the providers of Washington Medical Group, P.C. to disclose my health care prognosis only to the family members listed below. I understand that this authorization is voluntary.

1) _____ _____
Name Relationship

2) _____ _____
Name Relationship

3) _____ _____
Name Relationship

_____ _____
Print Name Date

_____ _____
Signature Witness

OR

☐ Check this box if you **DO NOT PERMIT** Washington Medical Group, P.C. to discuss your health care prognosis to any family member.

_____ _____
Print Name Date

_____ _____
Signature Witness