Wellness First P.C.
V. M. Patterson M. D.

Patient Information

Preferred Pharmacy/Phone/Location:_____

How did you hear about our office?_____

Last Name_____ First_____Middle_____

DOB_____ Gender_____Social Security Number_____Race____Ethnicity____

Marital Status_____Drivers License_____Religion_____

Address_____
mailing address city state zip code
(if mailing address is P.O. Box, what is physical address)

_____

Home Phone_____ 2nd phone (cell)_____

Patients Employment: Employed Retired Unemployed Student Disabled

Patient Employer/School_____Phone_____

In Case of an Emergency Contact_____Phone_____

Email Address_____
(this will be used for emailing lab results, appt reminders, etc.....)

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD TO THE FRONT DESK)

Primary Insurance_____ Secondary Insurance_____

Name of Insured_____ Name of Insured_____

Insured Date of Birth_____ Insured Date of Birth_____

Inured ID#_____ Insured ID#_____

Group#_____ Group #_____

Group Name_____ Group Name_____

Please List Names of Anyone (including physicians) That We Can Release Information To:

_____

Wellness Firt P.C.
Office Policies
Financial Policies

PAYMENT POLICY- Co-pays and deductibles are due at time of service for those insurance policies we are contracted with. For those insurance policies that we are not contracted with, we will gladly file your insurance claim however,payment will be requested at time of service. It is your responsibility to ensure that we are contracted with your insurance. Patient will be responsible for fees that exceed the payment made by your insurance company.

RELEASE INFORMATION- I authorize the release of medical information to my referring or consulting physicians. I also give permission to give medical information to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physicians.

MEDICARE- We are a participating provider of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying 20% co-payment at the time of service. We will bill secondary/supplemental carriers. However, in the event that the secondary carrier does not pay within 60 days, patient will be billed.

NO-SHOW APPOINTMENTS- An appointment confirmation call will be made 1 to 3 days prior to your scheduled appointment date and time. Due to the increased volume of no show appointments we will charge a $25.00 fee to your account. If this is not paid it will be turned over to collections. It is the patient's responsibility to inform our office of any changed phone numbers and/or addresses.

FOLLOW UP APPOINTMENTS- You may be asked to schedule a follow up appointment for lab results and or test order by Dr. Patterson. This is to ensure that you receive the best medical treatment possible. Each appointment, co pays will be due and an insurance claim will be processed.

******If you do not pay your bill or attempt to make payment arrangements, you will be turned over to collections!

I have read and understand the financial policy. I hereby authorize payment of medical benefits for all covered services to be paid directly to Wellness First P.C./Dr. Patterson. I accept financial responsibility for any service(s) provided to me not covered by my insurance policy. If the practice does not participate with my insurance, I also accept responsibility for fees that exceed the payment made by my insurance company. I understand that all co-payments will be due when I check in for an appointment. This practice accepts cash, checks, money orders, VISA, MC and Discover.

Patient/Guardian Signature _____ Date _____

Wellness First PC
641Hospital Road Ste. 4
Commerce, GA 30529

HIPPA Consent Form

Patient Name:_____ Date of Birth:_____

Our office may need to contact you concerning appointments, lab and/or imaging results. Please Check **ALL** that apply:

Home telephone # _____

☐ OK to leave a message with detailed information.

Or

☐ Leave message with call back number only.

Cell Phone # _____

☐ OK to leave a message with detailed information.

Or

☐ Leave message with call back number only.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I give permission for Wellness First and Dr. Patterson and her staff to disclose my personal medical information to the following individual (s):

Name:_____ Relationship to patient_____ Phone_____

Name:_____ Relationship to patient_____ Phone_____

Name:_____ Relationship to patient_____ Phone_____

Conditions for Disclosure: (**check the item(s) that apply**):

☐ The Practice may disclose my personal information to the individual(s) above only in my presence.

☐ The practice may disclose my medical information to the individual(s) above both both in my presence and when I am not physically present, including disclosures by telephone, answering machine, fax, e-mail or regular mail.

☐ Other conditions of Disclosure: (specify)_____

_____

I understand that this consent may be revoked by me at any time by written notice. I am aware that should the above information change I need to notify Wellness First so that changes may be made.

Patient Signature:_____ Date_____

Wellness First PC
Dr. Veronica M. Patterson

641 Hospital Rd. Ste 4
Commerce, GA 30529
Phone: 706-335-2777
Fax: 706-335-2788

Medical Records Release

_____ _____
Patient Name Date of Birth

_____
Patient Address

I hereby authorize for Wellness First PC to release or obtain any and all information including any psychiatric or psychological information regarding drug abuse or alcoholism and any information regarding sexually transmitted diseases (including AIDS infection) or HIV testing.

Release Information To:

Dr. Veronica M. Patterson

641 Hospital Road Ste. 4
Commerce, GA 30529

Phone: 706-335-2777

Fax: 706-335-2788

Obtain Information From:

_____
Physician/Institution/Agency

_____
Address

_____
City, State, Zip

_____
Telephone Number

_____
Fax Number

For the purpose of ____Medical Treatment and coordination of care. ____ Other.
I understand that I may revoke this authorization at any time in writing and present my written revocation Wellness First PC

_____ _____
Patient Signature Date

Health History

Name_____DOB_____

Reason for today's visit(in detail)_____

_____

Drug Allergies Yes or No (circle one) If yes allergies include:_____

_____

When was your last tetanus shot?_____Flu Vaccine_____Pneumonococcal?_____

Past Medical History:(check all that apply)

___Heart Disease __High Blood Pressure ____High Cholesterol ____Diabetes

___Thyroid problems ___Depression ____Kidney Disease ___Asthma

___Cancer(specify)_____

___Other(specify)_____

___ Injury(specify)_____

Surgical History: _____

_____

Any Family History of Cancer, heart problems, etc. yes or no, if YES list:_____

_____

Do you drink alcohol? YES or NO How often? _____ Beer Wine Liquor

Do you smoke? YES or NO How much?_____ Quit YES/NO How long ago?____

Do you use or have you ever used illicit drugs? YES or NO If YES, how much, how often and what type?_____

Signature of Patient _____ Date _____

Wellness First P.C.

MEDICATION RECORD

Patient's Name: _____ D.O.B. _____

Drug Allergies: _____

Latex Allergies: YES NO

Pharmacy: _____ Location: _____ Phone: _____

Medication	Dosage