The Clinic of Welsh, LLC

FIRST NAME _____ MI _____ LAST NAME_____

if minor, Name of Guardian / Parent_____ Male/Female (circle one)

D.O.B ____/____/_____ SS# _____-_____-_____

ADDRESS (WHERE YOU RECEIVE YOUR MAIL) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____-_____ CELL PHONE (_____)_____-_____

PLACE OF EMPLOYMENT _____ WORK PHONE (____)____-_____

ETHNICITY: NOT HISPANIC/LATINO HISPANIC/LATINO REFUSE TO ANSWER

PREFERRED LANGUAGE: ENGLISH SPANISH FRENCH OTHER _____

RACE _____ ____ REFUSE TO ANSWER

HAVE YOU SEEN A SPECIALIST OR ANY OTHER PHYSICIAN PRIOR TO THIS APPT? YES NO

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE NAME _____ POLICY HOLDER _____

POLICY HOLDER DOB ____/____/_____ SS# ____-____-_____ RELATIONSHIP_____

POLICY HOLDERS PLACE OF EMPLOYMENT _____ PHONE (___)___-_____

SECONDARY INSURANCE NAME _____ POLICY HOLDER _____

POLICY HOLDER DOB ____/____/_____ SS#____-____-____ RELATIONSHIP_____

POLICY HOLDERS PLACE OF EMPLOYMENT _____ PHONE (___)____-_____

I HEREBY AUTHORIZE THE CLINIC OF WELSH, LLC TO RELEASE AND/OR RECEIVE ANY AND ALL INFORMATION: (1) INFORMATION REQUESTED BY MY INSURANCE COMPANY, WORKMAN'S COMPENSATION CARRIER, ATTORNEY OR REHABILITATION. (2) INFORMATION TO ANY HOSPITAL OR PHYSICIAN I MAY BE REFERRED TO AND /OR (3) INFORMATION FROM HOSPITALS OR PHYSICIANS WHO HAVE PREVIOUSLY RENDERED TREATEMENT TO MYSELF. I UNDERSTAND THAT I AM ULTIMATLY RESPONSIBLE FOR PAYMNT OF ANY AND ALL CHARGES AND IF THIS ASSISNMENT OF CLAIMS IS REJECTED, MODIFIED, OF NOT PAID WITHIN A REASONABLE TIME AFTER IT HAS BEEN FILED, IT MAY BE MY RESPONSIBILITYY TO PAY ANY UNPAID CHARGES IN FULL. I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE CLINIC OF WELSH, LLC.

PATIENT'S NAME (PRINT) _____

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE ___/___/____

The Clinic of Welsh, LLC

CONFIDENTIAL COMMUNICATION REQUEST

AS REQUIRED BY THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), YOU HAVE THE RIGHT TO REQUEST THAT COMMUNICATIONS CONCERNING YOUR PERSONAL HEALTH INFORMATION BE MADE THROUGH CONFIDENTIAL CHANNELS. I HEREBY REQUEST THE USE OF THE FOLLOWING CONFIDENTIAL CHANNELS FOR THE COMMUNICAITON OF INFORMATION RELATED TO MY PERSONAL HEALTH, TREATMENT OR PAYMENT FOR TREATMENT WHICH INCLUDES MY INSURANCE COMPANY.

MAY WE DICUSS YOUR PERSONAL HEALTH INFORMATION WITH ANYONE ELSE? (YOU MUST FILL IN THE NAMES AND IT SHOULD INCLUDE PHYSICIANS WHOM YOU SEE REGULARY) WE CANNOT GIVE ANYONE YOUR APPOINTMENT TIMES UNLESS THEY ARE LISTED HERE!

1. _____ RELATIONSHIP_____PHONE: (____)____-_____
   (Can this contact also be used for emergency contact yes___ no____)
2. _____ RELATIONSHIP_____PHONE: (____)____-_____
3. _____ RELATIONSHIP_____PHONE: (____)____-_____
4. _____ RELATIONSHIP_____PHONE: (____)____-_____

THIS REQUEST IS TO INFORM YOU THAT OUR OFFICE WILL CALL THE NUMBERS LISTED ON YOUR MEDICAL RECORDS TO SCHEDULE YOUR APPOINTMENTS AND PROVIDE TEST RESULTS TO YOU. IF YOU HAVE ANY OBJECTION TO OUR STAFF LEAVING MESSAGES ON AN ANSWERING MACHINE, VOICEMAIL, OR WITH SOMEONE AT THESE NUMBERS, PLEASE NOTIFY THE FRONT RECEPTIONIST AT YOUR APPOINTMENT TODAY. WE WILL ONLY PROVIDE HEALTH INFORMATION TO THE NAMES ABOVE. WE MAY ALSO SEND CORRESPONDENCE VIAL MAIL TO THE ADDRESS YOU PROVIDE.

OUR OFFICE PARTICIPATES IN E-PRESCRIBING, YOUR PRESCRIPTION WILL BE SENT DIRECTLY TO YOUR PHARMACY. OUR PROVIDERS WILL ALSO OBTAIN YOUR MEDICATION HISTORY FROM OUR E-PRESCRIBE DATABASE.

NOTIFICATION PREFERENCES

PLEASE SELECT THE WAY YOU WOULD PREFER TO RECEIVE NOTIFICATIONS:

RECEIVE APPOINTMENT NOTIFICATIONS BY:	____ E-MAIL	___SMS (TEXT)	___ Call
RECEIVE LAB/TEST RESULTS NOTICATIONS BY:	____ E-MAIL	___SMS (TEXT)	___ Call
RECEIVE NEW MESSAGE NOTIFICATIONS BY:	____ E-MAIL	___SMS (TEXT)	___ Call

IF YOU WOULD LIKE TO PARTICIPATE IN OUR PATIENT PORTAL, PLEASE PROVIDE TO US YOUR **E-MAIL** ADDRESS

Email:_____

Phone / Cell # _____

PATIENTS RIGHTS AND RESPONSIBILITIES

PATIENTS RIGHTS AND RESPONSIBILITIES ARE POSTED IN OUR OFFICE WAITING ROOM FOR YOUR REVIEW. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE OFFICE MANAGER.

PATIENT NAME (PRINT) _____

PATIENT / GUARDIAN SIGNATURE _____ DATE____/____/_____

The Clinic of Welsh, LLC

Financial Policy

THANK YOU FOR CHOOSING THE CLINIC OF WELSH, LLC AS YOUR PRIMARY HEALTHCARE PROVIDER. WE ARE COMMITED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT. PAYMENT IS DUE AT TIME OF SERVICE. YOUR CO-PAY, CO-INSURANCE OR DEDUCTIBLE IF APPLICABLE MUST BE PAID AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECK, AND CREDIT CARDS. IF YOU HAVE AN OUTSTANDING BALANCE OF 120 DAYS OR MORE WHERE NO EFFORT HAS BEEN MADE, YOU SHOULD CONTACT OUR OFFICE FOR PAYMENT ARRANGEMENTS. ALL SERVICES WILL BE CEASED UNTIL PAYMENT OFACCOUNT BALANCE ARANGMENTS ARE MADE.

WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. WE ARE CONTRACTED WITH MOST INSURANCE PLANS AND IF WE ARE NOT, WE WILL DO OUR BEST TO ENROLL TO HELP IN YOUR TREATMENT. WE ACCEPT MEDICARE ASSIGNMENT, HOWEVER, YOU ARE RESPONSIBLE FOR YOUR DEDUCTIBLE EACH YEAR PLUS YOUR 20%.

AUTHORIZATION

1. GENERAL CONSENT TO TREATMENT- I AGREEAND CONSENT TO MY PHYSICAL EXAMINATION BY MY PHYSICIAN. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENTS MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARENTEES, EXPRESSED OR IMPLIED, AS TO THE RESULT OF ANY PROCEDURE OR MEDICAL TREATMENT.
2. RELEASE OF INFORMATION- I AUTHORIZE THE PHYSICIAN PROVIDING SERVICES ON MY BEHALF TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSURANCE COMPANY, HMO, EMPLOYER, PERSON ACTING ON BEHALF OF THE PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON COMMUNICATION FORMS, WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT OR WORKERS COMPENSATION UTILIZATION REVIEW. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THE OFFICE MANAGER.
3. ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE-I AUTHORIZE ANY THIRD PARTY PAYER TO PAY DIRECTLY TO THE PHYSICAN PROVIDING THE SERVICE TO THE PATIENT, ALL BENEFITS DUE AND PAYABLE AS A RESULT OF SERVICES RENDERED.
4. AKNOWLEDMENT OF RESPONSIBILITY TO PAY FOR SERVICES- I UNDERSTAND, ACNKOWLEDGE, AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY AND CHARGES WHICH FOR ANY REASON ARE NOT PAID BY ANY THIRD PARTY PAYER UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN PATIENT AND THE PAYER.
5. MEDICARE PATIENTS – I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS TO BE MADE TO MY PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THIS PROVIDER. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS OF MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.
6. AUTHORIZATION AND RELEASE- INSURERS AND MANAGED CARE COMPANIES OCCASIONAL REVIEW MEDICAL CHARTS TO INSURE COMPLIANCE WITH COMPANY PROCEDURES. I UNDERSTAND THAT MY CHART MAY BE SELECTED FOR SUCH A REVIEW AND THAT THE CONFIDENTIALITY OF THE INFORMATION IN MY CHART WILL BE PRESERVED AND I HEREBY CONSENT TO SUCH A REVIEW AND RELEASE THE PHYSICIAN AND ANY SUCH INSURER OR MANAGED CARE COMPANY FOR LIABILITY FOR REASONABLE REVIEW OF MY CHART.

PRIVACY PRACTICES

YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OR YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOVE YOUR PROTECTED HEALTH INFORMATION. YOU MAY OBTAIN A COPY AT ANY TIME FROM OUR OFFICE. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME WITH WRITTEN NOTICE TO OUR OFFICE MANAGER.

I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES ABOVE, CLINIC GUIDELINES PROVIDED, AND PRIVACY PRACTICES:

PATIENT NAME (PRINT) _____

PATIENT / GUARDIAN SIGNATURE _____ DATE ____/____/____

The Clinic of Welsh, LLC

Consent to Treat a Minor

Caregiver other than Parent/Guardian

Patient Name: _____ DOB: _____

I, _____, guardian, give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including but not limited to; examinations, diagnostic procedures including laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations/ injections) of my teen child (17 years and younger) without requiring the presence of an adult. However, if my teen needs immunizations/injections and comes alone, a parent/guardian must be available by phone for verbal consent.

Name _____ Phone Number _____

Relationship to Child _____

Name _____ Phone Number_____

Relationship to Child _____

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment may be refused or delayed. I understand that in an emergency, effort will be made to contact me prior to rendering treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify The Clinic of Welsh.

I have read all the information above and certify that the information I have provided here is true and correct to the best of my knowledge.

Name _____ Date_____

Relationship to Minor _____