HOPE WELLNESS AND RECOVERY CENTER

PATIENT REGISTRATION FORM (office use only) ACCOUNT #_____ Chart # _____

PATIENT NAME: (Last)_____(First)_____

DOB _____/_____/_____SOCIAL SECURITY#:_____

ADDRESS:_____CITY:_____STATE:____ZIP _____

HOME PHONE:_____CELLPHONE:_____OTHER:_____

BEST FORM OF CONTACT: HOME/CELL/WORK/EMAIL ADDRESS:_____@_____._____

BEST TIME TO CONTACT:_____MAY WE LEAVE A DETAIL MESSAGE REGARDING YOUR VISIT? Y 0R N

EMERGENCY CONTACT

NAME:_____RELATIONSHIP:_____

PHONE:_____RELATIONSHIP:_____

EMPLOYMENT

EMPLOYER:_____

PHONE:_____OCCUPATION:_____

RESPONSIBLE PARTY (IF UNDER THE AGE OF 18)

NAME: (Last)_____(First)_____

DOB:____/_____/_____SOCIAL SECURITY #:_____/_____/_____GENDER M / F Relationship:_____

INSURANCE INFORMATION

PRIMARY: (Insurance Company)_____

Subscriber's Name:_____DOB_____SS#_____

SECONDARY: (Insurance Company)_____

Subscriber's Name:_____DOB_____SS#_____

The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided.

DATE_____SIGNATURE_____(Policy Owner Subscriber)

AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier or Medicare for payment. I authorize any holder of medical and other information about me to release to insurance carriers or the Health Care Financing Administration and its agents or the Social Security Administration or its intermediaries or any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. The patient or his/her representative recognizing the need for healthcare, consents to the above listed medical provider rendering services ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. * Privacy policy Hope Wellness Center does not share or sell your email address information. If you do not wish to receive e-mail correspondence from Hope Wellness Center, please check this box. ☐

FINANCIAL POLICY

Patients are responsible for all co-pays, deductible and any other charges for the services performed by us and not paid by patient's insurance. Patients are responsible to verify with their insurance if we, the provider of medical services, are covered medical provider and also to find the benefits available to patient for our services. Patients are responsible to arrange the referral from their PCP and/or any other authorization, if required by the patient's insurance. Our staff is available to assist patient in this regard or to answer any question the patient might have. Co-payment and deductibles are expected at the time of service. We accept cash, checks, and credit cards. Self-pay patients are required to pay their charges on the date of service. **If at any time the patient defaults on this agreement resulting in collection proceedings, the patient understands that he/she shall be responsible for any and all of the a) interest, b) collection costs including but not limited to third-party collection fees and costs, and c) all legal fees and court costs.**

DATE_____SIGNATURE_____

HOPE WELLNESS AND RECOVERY CENTER

(office use only) Account # _____ Chart # _____

Patient Name: _____DOB:_____

How did you hear about us: _____?

Who can we thank for telling you about us? _____

What is your reason for your visit today?

Do you have a current diagnosis of Tuberculosis or have you ever been diagnosed with Tuberculosis disease?
☐ YES ☐ NO

Medications being taken: ☐ NONE

Name of Medication (s):	Dosage of Medication(s)	How often is the medication taken

Medication Allergies: ☐ NONE

Name of Medication	Reaction of Medication

_____ _____

Signature of Patient or Legal Representative Today's Date

HOPE WELLNESS
AND RECOVERY CENTER

CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Hope Wellness and Recovery Center. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless you object, we will call to confirm an appointment and / or leave a message, call you regarding your account (at the phone # provided by you), call and / or leave a message regarding treatment and / or test results.

Patient Name: _____ SSN: _____

Patient Signature: _____Date: _____

Name of the Patient Representative (or Guardian): _____

Relationship to Patient: _____ Sign & Date:_____

Hope Wellness and Recovery Center

Self Pay Policy

Self-pay patients are required to pay prior to being seen. Our discounted charges for self pay patients are:

Office Visit charges:

New Patients - $150

Established Patients - $115

Please note that the above charges are for office visits only. If the Physician decides to perform additional procedures like injections, sutures, X-rays, then **additional charges may be incurred.**

No self-pay patient can be checked in without prior payment of office visit charges as stated above.

Patient Signature _____ Date _____