INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER
6038 Norling Loop, Crystal River, FL 34429
Ph: (352) 563-5070 Fax (352) 795-4322

Referred by: ☐ Friend ☐ Radio ☐ Online ☐ Newspaer ☐ Mailer ☐ Google ☐ Insurance ☐ Employee

PATIENT NAME:________________________SOCIAL SECURITY NUMBER: ____________DOB: ______________

ADDRESS: ____

ZIP CODE: ______________ CITY: ______________________________STATE__________________

HOME PHONE: __________________CELL PHONE: __________________WORK PHONE: __________________

EMAIL ADDRESS: ____

SEX: ○ MALE ○ FEMALE RACE: ________ MARITAL STATUS ○ SINGLE ○ MARRIED ○ WIDOWED ○ DIVORCED

EMERGENCY CONTACT: ______________________________PHONE: ______________________

CONTACT'S RELATIONSHIP TO PATIENT: ____

EMPLOYMENT STATUS: ☐ FULL ☐ PART-TIME ☐ RETIRED ☐ UNEMPLOYED

EMPLOYER/SCHOOL: ____________________________ PHONE: ____________________________

RESPONSIBLE PARTY

SAME AS ABOVE : NAME:____

SOCIAL SECURITY NUMBER:____________________________ DATE OF BIRTH: ______________________

ADDRESS: ____

ZIP CODE: ________________ CITY: ______________________________STATE:__________________

HOME PHONE: ________________CELL PHONE :________________ WORK PHONE: ______________________

INSURANCE INFORMATION

1 PRIMARY INSURANCE COMPANY NAME: ____

CARDHOLDER'S NAME AS ON CARD: ____

CARDHOLDER'S RELATIONSHIP TO PATIENT: ________________CARD HOLDER SS#: ______________________

CARDHOLDER' S DATE OF BIRTH: ____

INSURANCE ID #:________________________INSURANCE GROUP #: ______________________

SEND CLAIMS TO: ____

2. SECONDARY INSURANCE COMPANY NAME ____

CARDHOLDER'S DATE OF BIRTH ____

INSURED'S RELATIONSHIP TO PATIENT________________CARDHOLDER SS# ______________________

INSURANCE ID # ________________________INSURANCE GROUP # ______________________

PEDIATRICS NEW PATIENT HISTORY

NAME;___________________________ DATE:________________ MRN#:____

Accompanied by: ☐ Mother ☐ Father ☐ Grandparent ☐ Other ____

Chief complaint: ☐ well child exam ☐ sick with: ____

Current habits:

Bowels: ☐ Brown ☐ Yellow ☐ Hard ☐ Soft ☐ Watery ☐ Daily ☐ With each feed ☐ 2-3 times/day

☐ Every other day Feeding: ☐ Regular meals ☐ Picky eater ☐ Formula ☐ Breast _____ OZ every ______hrs. brand _________

Sleeping: ☐ Sleeps through the night ☐ Wakes at night ☐ Bedtime ____pm Vision: ☐ No difficulty ☐ Decreased vision

Hearing: ☐ No difficulty ☐ Decreased hearing Dentist: ☐ Regular care ☐ Never ☐ As needed

Past medical history:

Newborn history: ☐ Full term ☐ Premature _______wks

- Mom's blood type ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Rh-
- Mom was +/- for Hepatitis B + / --____ GBS + / --____ Chlamydia + / --____ HIV + / --____ Rubella + / --____ PPD + / --____
- Vaginal delivery ☐ Cesarean section
- Prenatal complications ____
- Neonatal complications: ☐ Jaundice ☐ Sepsis ☐ low sugar ☐ antibiotics ☐ feeding problem
- Hearing screen ☐ Pass ☐ Fail

Medical diagnosis: ____

Surgeries: ____

Allergies: ____

Medications: ____

Family History:

	Diabetes	High Blood Pressure	High Cholesterol	Heart murmur	Kidney Failure	Cancer	Arthritis
Mom							
Dad							
Other							

Social History:

Day care: ☐ None ☐ Licensed ☐ Relative ☐ Home w/sitter ☐ Private home

Smoking: ☐ Smokers in home ☐ Smokes ☐ Cigarettes ☐ Pot

Pets in Home : ☐ Dog ☐ Cat ☐ Bird ☐ Fish ☐ _________________________ Other

Parents work:	At home	Outside home	Jail
Mom			
Dad			

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PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____

Signature of patient or responsible party

PAYMENT AND TREATMENT AUTHORIZATION

I, the undersigned, authorize payment of medical benefits to Internal Medicine & Pediatrics Wellness Center P.L. and authorize the release of medical information necessary to process my insurance claim(s). I understand that I am responsible for all charges regardless of insurance coverage.

________ Initials.

I authorize my physician to provide immunizations and perform tests and procedures deemed necessary for my/ my child's care in the office _______Initials. I also consent to the release of information to a provider I am referred to for specialized care_________Initials.

SIGNATURE____ DATE: ____________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INTERNAL MEDICINE AND PEDIATRICS WELLNESS CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Internal Medicine and Pediatrics Wellness Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Internal Medicine and Pediatrics Wellness Center or received by Internal Medicine and Pediatrics Wellness Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Internal Medicine and Pediatrics Wellness Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.1

Internal Medicine and Pediatrics Wellness Center reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Internal Medicine and Pediatrics Wellness Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies. For example, Internal Medicine and Pediatrics Wellness Center may determine that you require the services of a specialist. In referring you to another doctor, Internal Medicine and Pediatrics Wellness Center may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Internal Medicine and Pediatrics Wellness Center to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing
- claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you. For example, Internal Medicine and Pediatrics Wellness Center will submit
- claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Internal Medicine and Pediatrics Wellness Center may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Internal Medicine and Pediatrics Wellness Center may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders. We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Internal Medicine and Pediatrics Wellness Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- • As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- • For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.
- For health oversight activities.
- We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety. We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For workers' compensation. We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed. Internal Medicine and Pediatrics Wellness Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Internal Medicine and Pediatrics Wellness Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Internal Medicine and Pediatrics Wellness Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Internal Medicine and Pediatrics Wellness Center may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Internal Medicine and Pediatrics Wellness Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Internal Medicine and Pediatrics Wellness Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Internal Medicine and Pediatrics Wellness Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.
You may request to receive an accounting of the disclosures of your protected health information made by Internal Medicine and Pediatrics Wellness Center for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization. You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Internal Medicine and
Pediatrics Wellness Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Internal Medicine and Pediatrics Wellness Center, please contact the Privacy
Officer at the following:

Dr. Carlene Wilson
Internal Medicine and Pediatrics Wellness Center
6038 W. Nordling Loop
Crystal River, FL 34429

Phone: (352) 563-5070 Fax: (352) 795-4322

It is the policy of Internal Medicine and Pediatrics Wellness Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

1 This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520, and applicable Wisconsin healthcare privacy laws.

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PH: (352) 563-5070 FAX: (352) 759-4322
WWW.DRWELLNESSCENTER.COM

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I____acknowledge that I have received a copy of
(Name of patient)
Internal Medicine & Pediatrics Wellness Center's Notice of Privacy Practices. This Notice describes how Internal Medicine & Pediatrics Wellness Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____

(Signature of Patient, or Personal Representative) (Date)

____

(Relationship to Patient)

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I ____ am authorizing Internal Medicine & Pediatrics Wellness Center to give medical information to:

____

(Name of authorized person/persons)

☐ Do ☐ Do not give bill and account information to above named person/persons

DO NOT DISCLOSE MEDICAL INFORMATION TO ANYONE OTHER THAN MYSELF ________________

Initial

Please indicate how you would like us to communicate appointments and test results : Email like regular mail can be intercepted, therefore only normal results and messages will be sent this way.

☐ Do ☐ Do not: Email me : If yes: address____

☐ Do ☐ Do not Leave messages on answering machine or voicemail

☐ Do ☐ Do not Call me at home if not, please provide alternate telephone contact information:

____

☐ Do ☐ Do not mail appointment reminders or other correspondence to my home. If not, please provide alternate mailing address:

____

____

This remains in effect until I give written notification to discontinue.

____________________________________ ______________________

Signature of Patient or Legal Guardian *Date*

Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information or minors

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:____ **Date of Birth:** ____________

Previous Name:______________________________________Social Security #:______________

I request and

to release healthcare information of the patient named above to:

Carlene Wilson MD • 6038 W. Nordling Loop • Crystal River, Fl 34429

This request and authorization applies to: ____

Healthcare information relating to the following treatment, condition, or dates:__________________

____

All healthcare information from the last 3 years____

Other: ____

All healthcare information ____

____

☐ Yes ☐ No ______________ I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

☐ Yes ☐ No ______ I understand that I have the right to receive a copy of this authorization as well as refuse to sign this authorization and that, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization

Patient Signature:____Date Signed: ____________

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED