

Personal Information

Patient Last Name

Today's Date

Patient First Name

MI

Date of Birth

Sex Assigned Female Male
at Birth: Other Decline

Patient Preferred Name

Address Line 1

SSN#

Address Line 2

Responsible Party

City

State

Zip Code

Responsible Party Relationship

Home Phone

Cell Phone

Emergency Contact - Name

Work Phone

Work Phone Ext

Emergency Contact – Phone #

Email Address:

Emergency Contact Relationship

Ethnicity: Upper Mattaponi Tribal Member Asian
 American Indian/Alaskan Native Caucasian
 African American Other

Marital Single Married
Status: Separated Divorced
 Widowed N/A

Language Preference

Employment Employed Retired
Status: Student Other

Preferred Hospital

Hospital Phone#

Insurance Information

Insurance: Medicaid Other
 Medicare Self Pay

Insurance Plan

Policy ID #

Insurance PH #

Group # (if applicable)

Policyholder name (if not self)

Insured Signature

Purpose of Today's Visit

How did you hear about us?

Medical History

Please mark your response to indicate if you have or have not had the following?

	Yes	No		Yes	No
Artificial Heart Valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemo/Radiation.....	<input type="checkbox"/>	<input type="checkbox"/>
Previous Infective Endocarditis..	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, specify cancer.....</i>		
Atrial Fibrillation.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 or 2 Diabetes.....	<input type="checkbox"/> 1	<input type="checkbox"/> 1
High Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder.....	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Congestive Heart Failure.....	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>
C.O.P.D.....	<input type="checkbox"/>	<input type="checkbox"/>	G.I. Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	G.E.R.D./Heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Other Congenital Heart Defects.	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, specify.....</i>		
Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Psoriatic Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Systemic Lupus Erythematosus..	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	STD.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, specify.....</i>		
Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement: Have you had an orthopedic total joint replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>
			<i>If yes, specify:</i>		
			Do you have any condition or problem not listed above that we should know about?.....	<input type="checkbox"/>	<input type="checkbox"/>
			Have you seen any change in your general health during the last year?.....	<input type="checkbox"/>	<input type="checkbox"/>
			<i>If yes, what was the illness or problem?</i>		

Family History

Has your mother or father ever had any of the following?

Mother:

- Cancer
- Diabetes Type 2
- Heart Disease
- High Blood Pressure
- High Cholesterol

Father:

- Cancer
- Diabetes Type 2
- Heart Disease
- High Blood Pressure
- High Cholesterol

Other (Father):

Other (Mother):

Social History

Tobacco Use:

Have you ever smoked or vaped?

Yes

No

If yes:

Current – Daily Smoker

Former Smoker

of packs/day: _____

Current – Some Days

of years: _____

Alcohol:

Do you drink alcohol?

Yes

No

If yes:

Daily

Infrequently

of drinks/week: _____

Socially

Exercise:

Do you exercise?

Yes

No

If yes:

Daily

2-3 times / week

Type of exercise: _____

3-4 times / week

Occasionally

NOTE: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment.

I hereby certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my physician and staff will rely on this information. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my physician or any other member of staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature

Date

FAQ'S

Welcome Valued Patients to Aylett Family Wellness! The following are our current patient guidelines for existing patients as well as new patients:

MISSED APPOINTMENTS:

If you are unable to make your appointment, please can and either cancel or reschedule otherwise you may be charged for the visit. ***If you miss 3 appointments without calling or cancelling, then you may no longer be allowed to make appointments.***

TELEPHONE CALLS:

The physicians and clinical staff at Aylett Family Wellness attempt to be thorough and complete during your visit, which includes answering all your questions. You might notice that the provider you see is rarely interrupted by a telephone call during your visit. This is because we ask our patients to respect one another's time by saving questions for their appointment. We encourage patients to write down all questions and have them ready for their appointed provider.

In other words, Aylett Family Wellness physicians and nurses do not accept phone calls unless there are unusual circumstances. If you have a clinical question that you feel cannot wait until your next regularly scheduled visit, you may call Aylett Family Wellness. Your question will be assessed and triaged according to the clinical significance and responded to accordingly.

INSURANCE:

As a courtesy, Aylett Family Wellness will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards. Services that are performed by Aylett Family Wellness may require preauthorization from your insurance carrier. Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan. ***If any changes in your insurance coverage or benefits occur while being treated at Aylett Family Wellness you are responsible to notify us immediately.***

FINANCIAL POLICY:

I understand that if I am not **eligible** under the terms of my medical and hospital subscriber health insurance agreement, I am **liable for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the clinic.

CO-PAYS/ DEDUCTIBLES

If your insurance coverage requires co-pay, it will be collected when you check in or billed, before you see your provider. Deductibles are determined by your insurance company, and Aylett Family Wellness will notify you of your responsibilities after explanation of benefits are received.

MEDICAL RECORDS

If you request medical records from Aylett Family Wellness, there is no charge.

Patient/Responsible Party Signature

Date

PATIENT ACCOUNT TERMS & WAIVER OF LIABILITY

Billing:

Upon admission to Aylett Family Wellness, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, Aylett Family Wellness will agree to file your initial claim(s), provided we have complete insurance information and your Insurance forms at the time of admission (if forms are required). However, your health insurance contract(s) are between you and the insurance carrier. Because of this relationship, it is your primary responsibility to pay for services and provide follow-up communication with your health insurance carrier(s), if necessary. Regarding your insurance, they could deny payments for Office Visits & Clinical Procedures for one of the following reasons:

- 1. **Not a covered benefit**
- 2. **Not medically necessary**

Should your health insurance reject our claim for any reason, you are financially responsible. If your health insurance coverage requires the insured to pay a deductible and percentage or a copay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit. Payment can be made by check, cash, Visa, MasterCard, Discover Card, or American Express.

If you do not have health insurance, you will be required to pay at least \$20 at the time of visit and the rest of the amount can be settled through mailed reminders until the balance is paid off.

Aylett Family Wellness will accept what your insurance allows. Aylett Family Wellness will bill your insurance for you. However, most insurances are co-pay carriers, which means (for example) they will pay 80% of the allowed charges. You will be responsible for 20% of the allowed charges plus any deductible.

Agreement:

I have acknowledged that I understand and have received a copy of this notice. I agree to make payment for services rendered by Aylett Family Wellness according to the above terms. I authorize my Insurance to send payment directly to Aylett Family Wellness. I agree to pay a finance charge of one and half percent (1 ½ %) per month on all amounts due to and owing to Aylett Family Wellness.

_____ Date

Patient Name (*printed*)

_____ Date

Patient Signature

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES

_____ (Patient Initials) I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

RELEASE OF INFORMATION

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other Aylett Family Wellness affiliated facilities may be made available to subsequent Aylett Family Wellness affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s)	Relationship:	Contact Number:
Name(s)	Relationship:	Contact Number:

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

CONSENT TO EMAIL OR TEXT MESSAGE USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your wireless carrier for pricing plans and details).

CELL PHONE AUTHORIZED:

EMAIL AUTHORIZED:

Opt Out of text and email alerts: **Yes** **No**

Physician/Pharmacy Information

Are you now under the care of a physician or have a pharmacy? If yes, please complete the information below:

Physician Name	Physician Phone #
Current Pharmacy Name	Pharmacy Phone #
Current Pharmacy Address	Pharmacy Zip Code

If you want your previous medical records transferred from another facility to Aylett Family Wellness, please let a staff member know 😊

I ATTEST THAT ALL THE INFORMATION PROVIDED IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE

Patient/Guardian Signature:	Date:
Patient/Guardian Name (Printed):	Date: