Wellstone HEALTH PARTNERS

PLACE PATIENT STICKER HERE

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Date of Birth: / /

Social Security # - -	Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Prefix: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss.	Suffix: ❑ Jr. ❑ Sr. ❑ I ❑ II ❑ III	Race (optional): ❑ American Indian / Alaska Native ❑ Asian ❑ White ❑ Other ❑ Black or African American ❑ Hawaiian / Pacific Islander ❑ Declined ❑ Unknown	Ethnicity (optional): ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown ❑ Declined
Sex: ❑ Male ❑ Female					

Primary Language Spoken: ❑ English ❑ Spanish ❑ Other: _____	Secondary Language: ❑ English ❑ None ❑ Other: _____

Street Address:	Home Phone # ( )	Cell Phone # ( )

City:	State:	ZIP:	Email Address:

Occupation:	Employer:	Work Phone # ( )

Preferred method of phone communication (pick one): ❑ Home Phone ❑ Cell Phone ❑ Work Phone

Referred to clinic by: ❑ Dr. _____ ❑ Self Referred

Other family members seen here:

Preferred Pharmacy (Please include name & address)

Local Pharmacy: _____

Mail Order: _____

INSURANCE INFORMATION

Primary Insurance Carrier:	Primary Insured Member:	Relationship to the Primary Member:
Member ID #	Group Number:	Birth Date:
Secondary Insurance Carrier:	Primary Insured Member:	Relationship to the Primary Member:
Member ID #	Group Number:	Birth Date:

GUARANTOR / RESPONSIBLE PARTY

Name and address:	DOB: SS#:	Home Phone: Work Phone:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home Phone: Work Phone:

*This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Wellstone Health Partners** or my insurance company to release any information required to process my claims*

Patient/Guardian Signature Date:

Wellstone HEALTH PARTNERS

PLACE PATIENT STICKER HERE

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Address: _____

Date of Birth:_____ Social Security Number: _____

Authorizes ***Wellstone Health Partners***, to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip_____ Phone Number: _____

☐ Discuss with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? ☐ Yes ☐ No

May we contact you at home and/or leave a message regarding appointments? ☐ Yes ☐ No

The patient agrees that a photocopy of this authorization may be considered valid. This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

_____ _____

Signature of Patient or Representative **Relationship to Patient**

_____ _____

Date Signed **Witness Signature**

PLACE PATIENT STICKER HERE

WELLSTONE ENT OFFICE POLICIES

As a patient of Wellstone Health Partners I understand that the following policies are currently in effect:

- A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.
- A $25.00 may be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. I also understand this fee, if assessed, must be paid prior to my next visit with Wellstone Health Partners.
- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.

I understand additional procedures performed at the time of the office visit may be result in additional charges above my co-pay for the visit, according to my insurance and deductible. Permission to perform a procedure includes assumption of responsibility to pay the cost. Common examples of procedures that may result in additional charges include:

- **Nasal and laryngeal endoscopy**
- **Ear cleaning**
- **Removal of foreign objects**
- **Biopsies**
- **Treatment of nosebleeds**
- **Ear tube placement**
- **Treatment of dizziness**
- **Labs**

- **I am to present proof of my insurance coverage at *every* office visit**.
- **I understand if I am more than 15 minutes late for my scheduled appointment I *may* be asked to reschedule for another day.**
- **Finally, I understand that I am to allow at least 48 hours for my prescription refills**.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

_____ _____

Signature of Patient or Representative **Relationship to Patient**

_____

Date Signed

PLACE PATIENT STICKER HERE

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Wellstone Health Partners to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Wellstone Health Partners

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Wellstone Health Partners reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Wellstone Health Partners is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

_____ _____

Signature of Patient or Representative **Relationship to Patient**

_____

Date Signed