Wellspring Family Medicine

_____/_____/_____
Date

LAST NAME | FIRST NAME | MIDDLE INITIAL

ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE | (EXT)

PRIMARY CARE DOCTOR | REFERRING PHYSICIAN

_____/_____/_____ SEX: F M
DATE OF BIRTH

_____
SOCIAL SECURITY #

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED
LEGALLY SEPARATED

STUDENT STATUS: FULL TIME PART TIME NOT A STUDENT
RESPONSIBLE PARTY: SELF GUARANTOR RELATIONSHIP _____

EMPLOYMENT STATUS: FULL TIME NOT EMPLOYED RETIRED
PART TIME SELF EMPLOYED ACTIVE MILITARY

EMAIL ADDRESS

EMERGENCY CONTACT NAME | ADDRESS | CITY | ZIP

HOME PHONE | WORK PHONE | EXT.

PERMISSION TO LEAVE MESSAGE: HOME: YES NO WORK: YES NO

AUTHORIZATION TO RELEASE INFORMATION TO:

_____
NAME | RELATIONSHIP

_____
PHONE

PHARMACY NAME | LOCATION | PHONE | FAX

PRIMARY INSURANCE | POLICY HOLDER SEX

POLICY HOLDER SSN# | ID#

SECONDARY INSURANCE | POLICY HOLDER SEX

POLICY HOLDER SSN# | ID#

PRIMARY INSURANCE | POLICY HOLDER SEX

POLICY HOLDER SSN# | ID#

SECONDARY INSURANCE | POLICY HOLDER SEX

POLICY HOLDER SSN# | ID#

PATIENT, PLEASE SIGN FOR PERMISSION TO TREAT

IF PATIENT IS A MINOR, PARENT SIGN HERE FOR PERMISSION TO TREAT IN YOUR ABSENCE

Wellspring
Family Medicine

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have been informed a copy of Wellspring Family Medicine, Notice of Privacy Practices, is posted in the waiting room and in the central lab area. A copy of this Notice will be furnished to me upon my request.

_____

PATIENT SIGNATURE *DATE*

HIPPA is an acronym for the Health Insurance Portability * Accountability Act of 1996, (a Federal Law).
Of significant concern to healthcare organizations is the Administrative Simplification section of Act, which requires healthcare organizations to comply with specific rules regarding:

Unique Identifiers for health plans, providers, individuals, employers
Healthcare Transaction & Code sets for transmitting data electronically
Privacy regulations over disclosure and use of health information
Security regulations over protections of electronic health informations

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, ensuring machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a unauthorized person who may answer the telephone.
If you would like to have information released to someone other than yourself, please complete the following

I authorize Wellspring Family Medicine to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them when ever this information changes.

Home Telephone:	Yes	No	Voice Mail:	Yes	No
Answering Machine:	Yes	No	Cell Phone/Voice Mail:	Yes	No
Work Telephone:	Yes	No	Page:	Yes	No

May we fax medical records tor referrals? Yes No

Please list names of people we can discuss your medical care with:

Spouse Name:	Yes	No
Parent Name:	Yes	No
Other Name:		

_____

RELATIONSHIP *PHONE*

_____

SIGNATURE OF PATIENT/GUARDIAN *DATE*

Wellspring
Family Medicine

WELLSPRING FAMILY MEDICINE
FINANCIAL POLICY

At this time we accept cash, check, Visa, American Express, Discover, and Master Card as forms of payment.

If a check is returned to the office for insufficient funds, the original check amount plus $30.00 for returned check fee must be received within 30 days to avoid further late fees or collection action. Our office utilizes Preferred Health Technology to collect on accounts. You will be notified by their office regarding delinquent account(s).

PLEASE UNDERSTAND THAT IT IS ULTIMATELY THE PATIENT'S RESPONSIBILITY FOR THE PAYMENT OF SERVICES. If your insurance company does not pay the full amount of your visit you are responsible for non-covered services on remaining balances. Payment is due within 30 days of notification, your account will be accessed with a $10.00 late fee.

After a balance has reached 90 days past due, we will turn over your account to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action. The patient will be also responsible for any and all legal fees.

Please be aware that some services provided may be non-covered services under your policy. ***IT IS THE PATIENTS RESPONSIBILITY TO BE AWARE OF THE INDIVIDUAL'S POLICY RESTRICTIONS AND GUIDELINES.*** WELLSPRING FAMILY MEDICINE will not enter into any dispute with an insurance company, but we can assist you with any difficulties.

Note: All laboratory tests, injections, venipuntures, procedures that are not included as part of the office visit and will result in an additional expense.

Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change and appointment, please do so within 24 hours of an appointment. ***THE CHARGE IS $25.00 FOR ANY MISSED APPOINTMENT.***

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage and I am ultimately responsible for payment in full for outstanding balances. I understand that this information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform WELLSPRING FAMILY MEDICINE to perform any necessary services deemed appropriate by attending physician to make a thorough diagnosis. I also authorize WELLSPRING FAMILY MEDICINE and staff to perform any procedures, forms of treatment, medication, and therapy in connection with my diagnosis and treatment plan. Even though I may have health insurance coverage, I understand that payment of services is ultimately my responsibility. I understand that payment for services are due at the time that services are due at the time that services are rendered, unless other financial arrangements have been made.

PRINT NAME *SIGNATURE* *DATE*

Wellspring
Family Medicine

WELLSPRING FAMILY MEDICINE
NO SHOW/SAME DAY CANCELLATION POLICY

Our office requests a 24-hour notice of an appointment cancellation. In the event that a notification was not made, there will be a ***$25.00 FEE*** added towards the future appointment.

This fee is expected to be paid before seen by the physician.

WHEN (3) NO SHOWS/SAME DAY CANCELLATIONS HAVE BEEN ACCUMULATED WITHIN A CALENDAR YEAR, THE PATIENT WILL BE DISCHARGED FROM THE PRACTICE.

Please help us to better serve you and other patients by keeping all scheduled appointments.

I certify that I have read and understand the "No-Show/Same Day Cancellation Policy" and agree to all terms and conditions as stated above.

_____

PRINT NAME

_____

SIGNATURE *DATE*

Wellspring
Family Medicine

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby Authorize Wellspring Family Medicine to Use of Disclose my Protected Health Information as Described Below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

FIRST NAME *MIDDLE NAME* *LAST NAME*

ADDRESS *TELEPHONE NUMBER*

SOCIAL SECURITY NUMBER *DATE OF BIRTH*

NAME OF PERSON/FACILITY AUTHORIZED TO RELEASE MEDICAL RECORDS

ADDRESS *CITY* *STATE* *ZIP*

TELEPHONE NUMBER *FAX NUMBER*

NAME OF DOCTOR/FACILITY AUTHORIZED TO RECEIVE MEDICAL RECORDS FROM:
WELLSPRING FAMILY MEDICINE
110 ATRIUM WAY, COLUMBIA, SC 29223
PHONE: 803-865-9655, FAX: 803-865-9653

PURPOSE OF DISCLOSURE *DATES OF TREATMENT*

INFORMATION TO BE USED/DISCLOSED - PLEASE CHECK THOSE THAT APPLY:

HISTORY AND PHYSICAL	*DISCHARGE SUMMARY*	*OPERATIVE REPORT*
OTHER (SPECIFY) _____		*PROGRESS NOTES*
LABORATORY REPORT	*RADIOLOGY REPORT*	*IMMUNIZATION RECORD*
BILLING SUMMARY	*CONSULTATION REPORT*	*PATHOLOGY REPORT*
ENTIRE MEDICAL RECORD		

I understand that in event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS, that this information will be included as part of my medical record to the above - named person/facility.

This authorization is subject to cancellation at any time, by the patient of legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization or;
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

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This authorization will automatically expire in 90 days unless otherwise stated.

_____

EXPIRATION DATE

_____

SIGNATURE OF PATIENT OR LEGALLY QUALIFIED REPRESENTATIVE *DATE*

_____

RELATIONSHIP OF LEGALLY QUALIFIED REPRESENTATIVE

_____	_____	_____
MAILED DATE	*FAXED/DATE*	*PICKED UP DATE*

SUBMIT PRINT