James C. Wasson, M.D., P.C.

Registration Form

Please fill this form out completely. We will be unable to file your insurance claim without all of this information.

Patient_____ Age_____ Date of Birth_____
First Name **Middle Initial** **Last Name**

Address_____
Street **City/State** **Zip**

Primary Phone _____Secondary Phone _____Work Phone_____

Email address_____ □ None □ Decline to provide email

SS# _____-_____-_____ Gender: □ Male □ Female

Race/Ethnicity: _____□ Decline Language preference_____

Special Needs (i.e.. hearing, vision, mobility)_____□ None

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated **Military?** □ Active □ Retired

If married, spouse's name_____

Children's names and ages_____

Legal Guardian_____ Caregiver_____□ None

Patient Employer _____**Insured Employer**_____

Primary Insurance Company_____ □ HMO □ PPO □ Other

Policy Number_____GroupNumber_____

Policy Holder: □ Self □ Spouse □ Parent **If policy holder is spouse or parent we need the following:**

Name _____SS#_____-____-_____ Date of Birth_____

Secondary Insurance Company_____□ HMO □ PPO □ Other

Policy Number _____Group Number_____

Policy Holder: □ Self □ Spouse □ Parent **If policy holder is spouse or parent we need the following:**

Name _____SS#_____-____-_____ Date of Birth_____

Emergency Contact_____
Name **Relationship** **Phone Number**

New Patient : How did you hear about us? _____

James C. Wasson, M.D.

Today's Date_____

Medical History Form

Patient _____ Date of Birth _____
First Name **Middle Initial** **Last Name**

Allergies _____Drug Allergies _____Reaction_____

Reason for Visit _____

Occupation _____

Medications: **List all medications you are currently taking, prescribed and over the counter, including frequency and dosage amount.**

Medications	Dosage	Frequency

Medications	Dosage	Frequency

Family History: **From the list, check any conditions that may apply to your family history.**

M=Mother F=Father S=Sibling O=Other D=Deceased

Family History	M	F	S	O	D		Family History	M	F	S	O	D	
Heart Disease							Bleeding Disorder						
High Blood Pressure							Kidney Disease						
Stroke							Thyroid Disease						
Cancer							Mental Illness						
Glaucoma							Osteoporosis						
Diabetes							Psoriasis						
Epilepsy / Convulsions							Autoimmune Disorder						

Hospitalizations: **List hospitalizations for operations or serious illnesses (excluding pregnancy)**

Year	Reason

Year	Reason

Do you:	YES	NO
Smoke		
Packs daily? _____		
# Years? _____		
Interested in stopping?		
Drink alcohol		
How much? _____		
Type		
Drug Abuse		
How much? _____		
Type_____		

Women only:	YES	NO
Are you pregnant?		
Are you planning pregnancy?		

	YES	NO
Do you have a living will?		

List Hospital Preference:

_____

List Pharmacy Preference:

_____

_____

Assignment of Benefits

Patients name: _____DOB: _____

Release of Medical Information: I authorize James C. Wasson, MD, PC to release any medical information necessary for my care or treatment, or to process an insurance claim to evaluate medical necessity.

Signature _____Date_____

Responsibility for Payments and Assignment: My insurance is a contract between the insurance company and myself. I understand that I have full financial responsibility for all professional services rendered. I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I also understand that any balances due that are not paid in a reasonable amount of time will be forwarded to collection and I will be responsible for any cost incurred by the office to retrieve their moneys. I authorize James C. Wasson, MD, PC to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to James C. Wasson, MD. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to James C. Wasson , MD. I authorize James C. Wasson, MD, PC permission to contact the insurance commissioner on by behalf if claims are not paid or processed in 45 days according to state law.

Signature _____Date_____

Printed Name_____

For patients under the age of 18:

Treatment of a Minor: I, the undersigned parent or legal guardian of the above listed minor, do hereby authorize James C. Wasson, M.D. and his staff to perform any medical or surgical care or treatment which is deemed advisable, in the office or hospital. This consent shall remain in effect until legal age, unless revoked in writing.

Signature _____Date_____

Printed Name_____

Receipt of Privacy Act: I, _____, acknowledge that I have received a copy of the PHI from James C. Wasson, MD, PC. I realize that if at any time I have any questions regarding PHI I may contact the office.

Signature: _____

James C. Wasson, M.D., P.C. **Today's Date _____**

Patient_____ Date of Birth_____

Notice of Privacy Practices – Patient Acknowledgement

I have received notice of this practice's policy which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information and abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of uses and disclosures that are prohibited or materially limited by law and a description of the ones that will be made only with my written authorization and that I may revoke such authorization.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected heath information without my written consent or authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect, copy and amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new revisions effective for all protected health information that it maintains. I understated that I can obtain this practice's current Notice of Privacy Practices on request. (Signature below)

Communication Policy

It is the office policy of James C. Wasson M.D., P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone, and /or pager. Also, faxing patient information to your work place is prohibited. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize James C. Wasson, M.D., P.C. and /or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

	Yes	***No***
Home Telephone		
Answering Machine / Voice Mail		
Work Telephone		
Cell Phone and/or Voice Mail		
Fax medical records for referrals to another physician		
Spouse:		
Parent:		
Other: (State Relationship)		

Signature _____Date_____

Relationship to patient (if signed by a personal representative of patient):_____