AIMEE WRIGHT, D.O.

This form must be completed one (1) time per year per our office policy – NO EXCEPTIONS!

PATIENT REGISTRATION INFORMATION

Patient's Name_____ Today's Date_____
Last First MI Preferred Name

Street Address_____ Is patient a minor? ☐ Y ☐ N
Please Include Apt. #

City, State, Zip Code_____ Home Phone_____

DOB_____ DL # _____ State_____ Exp_____

SSN_____ Email Address_____

Employer & Occupation_____

Work Phone_____ Ext._____ Cell Phone_____

Parent/Guardian (If Applicable)_____ Daytime Phone_____

Spouse/Partner's Name_____ Daytime Phone_____

Preferred Contact # ☐ Home ☐ Work ☐ Cell

Is your condition the result of a work injury? ☐ Y ☐ N Auto Accident? ☐ Y ☐ N

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

****

If the GUARANTOR is someone other than the patient, please fill out this section. Check here if SELF. ☐

Guarantor_____ Guarantor DL# _____ ST_____ EXP_____

SSN_____ Relationship to patient_____

Guarantor's Home Address_____
Street City, State, ZIP

Guarantor's Phone_____ Work Phone_____ Ext._____

****

INSURANCE INFORMATION Check One: ☐ Cash Indemnity ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ Other

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST UPON ARRIVAL.

PRIMARY INSURANCE_____ INSURANCE PHONE_____

NAME OF INSURED_____ DOB_____

RELATIONSHIP TO PATIENT_____ DEDUCTIBLE_____

EMPLOYER_____ EMPLOYER PHONE_____

ID # _____ GROUP # _____ COPAY_____

MEDICARE # _____ INS. VERIFIED BY_____ DATE_____

MEDICARE SUPPLEMENT INSURANCE_____

ID # _____ GROUP # _____

EMERGENCY CONTACT_____ PHONE_____

RELATIONSHIP TO PATIENT_____

HOW DID YOU HEAR ABOUT US? _____

I hereby authorize payment of any insurance benefits to ABOVE NAMED PHYSICIAN. I understand I am financially responsible for the charges incurred whether or not they are covered by insurance. I hereby authorize ABOVE NAMED PHYSICIAN to release any and all information necessary to secure the payment of benefits. A photocopy of this document shall be a valid as the original. Guarantor files insurance for reimbursement. If additional physician time is required for formulary changes on your prescription, there will be a $10.00 fee for this service. This will not be covered by insurance and will be the patient's responsibility. **Motor vehicle accidents are fee for service. You will be supplied a fee slip to file your auto insurance. NO EXCEPTIONS.**

SIGNATURE_____ **DATE**_____

METHOD OF PAYMENT ☐ CASH ☐ CHECK ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS
HAVE YOU FILLED OUT CHECK CARD? ☐ YES ☐ NO
THERE IS A $30.00 CHARGE FOR RETURNED CHECKS! CHECKS WILL NOT BE TAKEN WITHOUT PROPER ID AND CHECKS OVER $50.00 WILL BE VERIFIED AT THE TIME OF SERVICE

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male ☐ Female ☐
Last Name First Middle			Daytime phone	Home Phone	
Address City State Zip			Marital Status	Occupation	
Person to notify in emergency	Daytime Phone	Relationship	Last Physical Examination Date		
By Doctor	Phone	Family or Referring Doctor	Phone No.		
May I contact either of these Doctors for your past health records? Yes ☐ No ☐	What are your present medical symptoms?				

Family History	IF LIVING Age	IF LIVING HEALTH Good Fair Poor	IF DECEASED Death Age	IF DECEASED Death Cause
Father				
Mother				
Brothers (Circle Sisters Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons (circle Daughters sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

	✔ Yes	No	Relationship		✔ Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Break'n			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease							

HABITS

Do You	✔ Yes	No	Daily Consumption:
Smoke	☐	☐	_____ Pkgs.
Drink Coffee	☐	☐	_____ Cups
Drink Alcohol	☐	☐	_____ oz.
Drink Beer	☐	☐	_____ oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✔ If Taken	✔	✔	✔	✔
Antacids	☐	Blood Thinning Pills ☐	Iron or Poor Blood Med. ☐	Vitamins ☐
Antibiotics	☐	Cortisone ☐	Laxatives ☐	Water Pills ☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine ☐	Phenobarbital ☐	Weight Reducing Pills ☐
Barbiturates	☐	Digitalis ☐	Shots ☐	Other (list) _____
Birth Control Pills	☐	Dilantin ☐	Sleeping Pills ☐	_____
Blood Pressure Pills	☐	Hormones ☐	Thyroid Med. ☐	_____
		Insulin, Diabetic Pills ☐	Tranquilizers ☐	_____

Operations you have had:	Year	Diseases you have had requiring hospitalization	Year	Serious illness not requiring hospitalization	Year

Drugs you are allergic to:

Describe any serious injuries or accidents you have had

WOMEN only:

	✔ Yes	No	
Are you still having regular monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When? _____
Do you have very heavy bleeding with your periods?	☐	☐	When? _____
Do you feel bloated and irritable before your period?	☐	☐	
Are you now on or have you ever taken the birth control pill?	☐	☐	When? _____
Have you ever had a miscarriage?	☐	☐	When? _____
Have you ever had a discharge from the nipple of your breast?	☐	☐	When? _____
Do you regularly have the cancer test of the cervix?	☐	☐	Date of last test _____

How many children born alive _____
How many stillbirths _____
How many premature births _____
Date of last menstrual period _____
How many miscarriages _____
How many cesarean operations _____
Any complications of pregnancy? (explain) _____

MEN only: Have you ever had:

	✔ Yes	No
Loss of sexual activity? For how long?	☐	☐
Treatment for genitals (private parts)?	☐	☐
Discharge from penis?	☐	☐
Hernia (rupture)?	☐	☐
Prostate trouble?	☐	☐

MEN and WOMEN:

	✔ Yes	No
Do you frequently have severe headaches	☐	☐
(If yes, answer the following):		
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

	✔ Yes	No		✔ Yes	No
Have you ever fainted?	☐	☐	Have you ever had a convulsion?	☐	☐
Spells of dizziness?	☐	☐	Double vision?	☐	☐
Spells of weakness of arm or leg?	☐	☐	Pains in ear?	☐	☐
Ringing in ears?	☐	☐	Nosebleeds?	☐	☐

Have you recently had [illegible] in the stomach which:

	✔ Yes	No
Occurs 1-2 hours after [illegible]	☐	☐
Is brought on by eating fried foods, gassy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Is relieved with milk or eating?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowel movement?	☐	☐
Causes loss of appetite?	☐	☐

Do you frequently have:	✔ Yes	No		✔ Yes	No
Bleeding gums?	☐	☐	A sore tongue?	☐	☐
Trouble swallowing?	☐	☐	Nausea and vomiting?	☐	☐
Hoarseness?	☐	☐			

Have you ever had shortness of breath?

	✔ Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had pain or tightness in the chest which begins:

	✔ Yes	No
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After a heavy meal?	☐	☐
When upset or excited?	☐	☐
Palpitations	☐	☐
Do you sleep on more than one pillow?	☐	☐

	✔ Yes	No
Radiates down the arm?	☐	☐
Disappears if you rest?	☐	☐
Occurs only at rest?	☐	☐
When walking fast?	☐	☐
When walking in cold weather?	☐	☐

If you have chest pain or tightness please explain.....

Have you had?	✔ Yes	No	When or since when?
Burning when urinating?	☐	☐	
Loss of control of bladder?	☐	☐	
Blood in the urine?	☐	☐	
Dark colored urine?	☐	☐	
Trouble starting to urinate?	☐	☐	
Trouble holding the urine?	☐	☐	
To get up frequently at night?	☐	☐	
Passed a kidney stone?	☐	☐	

Have you recently had:	✔ Yes	No	When or since when?
Pains in calves of legs when walking?	☐	☐	
Cramps in legs at night?	☐	☐	
Pain in the big toe?	☐	☐	
Varicose veins?	☐	☐	
Phlebitis or inflamed leg veins?	☐	☐	
Swelling in the ankles	☐	☐	

If you have had a change in bowel habit recently answer the following:	✔ Yes	No	When or since when?
Crampy pain in abdomen?	☐	☐	
Alternating diarrhea and constipation?	☐	☐	
Pain during or after bowel movement?	☐	☐	
Mucous in the stool?	☐	☐	
Blood in the stool?	☐	☐	
Ribbon like stools?	☐	☐	
Black stools?	☐	☐	
Require use of strong laxatives or enemas?	☐	☐	
_____	☐	☐	

Describe briefly your present medical symptoms and anything else we should know about your health.

DR. AIMEE L. WRIGHT

Diplomat, American Board of Family Medicine

Authorization for Use and Disclosure of Protected Health Information

Why this form?

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. The "privacy" rules within HIPAA require that health care providers and other entities maintain a specified level of security for Protected Health Information (PHI) which includes any *individually identifiable* health data. Therefore your physician must obtain written authorization from you, the patient, to release any of your medical information to any other individual. This includes your spouse, other doctors, relatives, or any other individual that may have a need to review your medical information.

It is important that you complete this form so that in the event of an emergency, your physician will have your prior consent to share your medical information with those individuals to whom you deem it necessary. We recommend that you include your spouse, parents, siblings, physicians, or other individuals as you see fit.

You may revoke this disclosure at any time and must do so in writing. Please do not hesitate to ask for further clarification of this document.

I, _____, hereby authorize the release of my **protected health information (PHI)** by Dr. Aimee Wright to the following persons:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.
- I understand that I have a right to revoke this authorization at any time. My revocations must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

Please sign this form so that we may comply with your request. Completion of this form will not in any way affect your eligibility for benefits.

I certify that I have read and understand this authorization form.

_____ _____

Signature Date

_____

Printed Name of Patient or Representative

Consent

To The Use And/Or Disclosure Of Protected Health Information For Treatment, Payment, Health Care Operations, And As Otherwise Allowed By Law

Aimee L. Wright, D.O., P.A. will maintain a record of the care and services you receive at the practice of Aimee L. Wright, D.O., P.A.. This consent only covers your protected health information created while a patient of Aimee L. Wright, D.O., P.A. Your protected health information pertains to your diagnosis and/or treatment at the practice of Aimee L. Wright, D.O., P.A, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Aimee L. Wright, D.O., P.A. use and/or disclosure of protected health information about you for treatment , payment, health care operations and as otherwise allowed by law. Our Notice of Protected Health Information Practices provides information about how Aimee L. Wright, D.O., P.A and its personal may use and/or disclose protected health information about you for treatment ,payment, health care operations and as otherwise allowed by law. **By signing this form, you also aknowledge that you have received a copy of Aimee L. Wright, D.O., P.A Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

_____

Signature of Patient or Legal Representative

_____

Witness

_____

Date

DR. AIMEE L. WRIGHT

Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibility is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

It is the responsibility of our patients to provide us with current, valid insurance information and inform our office of address changes. For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan **is due at the time of service**. It is your responsibility to be aware of your co-payment and if you've met your deductible. Payment is expected at time of each visit, either in full or the extent that a co-payment is required by your insurance. We do not offer charge accounts or payment plans.

We accept cash, Visa, MasterCard and American Express. We do not accept checks.

Delinquent accounts will be turned over to a collections service if not settled within 90 days. For all accounts that must be sent to a collections agency, a $50.00 fee will be added for processing.

Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, deductible and co-insurance at the time of service.

If you have insurance coverage under a plan with which we do not have a prior agreement, payment in full will be expected at time of service. You will be given the paperwork necessary to assist in filing your own claim.

We make every effort to follow the guidelines required by your insurance company. However, every contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is make to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect payment from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

After a claim has been processed and it is evident that the patient's financial responsibility is greater than was collected at time of service, then the financial guarantor will have 30 days to pay the balance owed in full. A late fee of $50.00 will be added to all account balances in excess of 90 days past due (even if the payment delay is due to the insurance company). Accounts with balances will be turned over to a collection company if not paid in completion in 90 days.

Precertification

We will try to fulfill all the requirements your insurance has for precertification, but we will not be responsible for any reductions in benefits if this is done.
Be sure and tell us if precertification is necessary BEFORE you have a procedure.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the custodial parent and/or guardian, for payment.

Missed Appointments

Failure to keep your appointment prevents other patients from being able to see the doctor during that time. This causes patients who are ill to wait unnecessarily for appointments and wastes both the doctor's and other patient's time. When you have to cancel, we ask for the courtesy of at least 24 hours advance notice so we may offer your time slot to another patient. Patients who do not cancel or reschedule their appointment at least 24 hours prior to their scheduled appointment may be charged a fee of $45.00.

Rescheduled Appointments

Rescheduling appointments may be necessary if:

- Patient is greater than 15 minutes late for appointment
- Patient is unable to meet the financial requirements for appointment
- Patient is unwilling to pay previous balance owed on account
- Patient is unwilling to pay for visit, when insurance is unverifiable

Form Completion by Physician

If you require a form to be filled out by our physician, you will be charged a $10.00 per page form fee. Please leave blank forms with receptionist. Please allow at least five business days for completion. Payment is due when form is returned to you.

If additional physician time is required for formulary changes on your prescription, there will be a $25.00 fee for this service.

Office Hours

8:30 – 5:30 Mon-Wed
8:30 – 7:30 Thursday
8:30 - 5:30 Friday

Telephone calls will be returned **by the staff, AFTER** review with the doctor. All calls are returned by the next business day.

All telephone requests for prescription refills, appointments and all other business of a non-emergency nature, must be made Monday through Thursday between 8:30 a.m. and 4:00 p.m. and Friday from 9:00 a.m. to 12 noon. If you should have an URGENT need to speak with the provider on call after hours you may call the provider on call. The provider will respond to bonafide urgent calls within two (2) hours. "Urgent" suggests a call needing a response within two (2) hours. After hours phone calls made to the provider on call may incur a charge. If you should have an emergency, please call 911.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and Agree that such terms may be amended from time to time by the practice.

I authorize the release of medical records to determine liability for payment or treatment, and to obtain reimbursement. I assign all medical and/or surgical benefits to Dr. Aimee L. Wright. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not they are paid by my insurance company.

_____
Printed Name of Patient or Legal Representative

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient Date of Birth

Policy revised May 2009