Wellness Doctor, Inc.
1693 SW Chandler Ave, Ste 280 Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

GENERAL INTAKE

*Remember to bring completed paperwork: (If paperwork is not completed, arrive **30 min prior** to appt.)

First Name:_____MI: ____ Last Name:_____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Carrier Company (text reminders): _____

Sex: __M__F DOB:___/___/_____ Age: ____Marital Status: __S__ M__D __W __P (partner)

E-mail: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____Phone: _____ Relationship: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? ___Yes ___No

Name of Medical Doctor/Facility: _____ Phone: _____

Who may we thank for your referral? _____

In compliance with the governmental EHR incentive program and CMS requirements, we ask the following:
Race (select one): __American Indian or Alaska Native __ Asian __ Black or African American
__Native Hawaiian or Pacific Islander __White __Other __I decline to answer

Ethnicity (select one): __Hispanic __Not Hispanic or Latino __I decline to answer

PRIMARY INSURED INFORMATION

If you are the responsible party, mark "self."

Person responsible for patient's charges: __Self __Spouse __Parent __Other: _____
Name: _____ Address: _____
City/State/Zip: _____
Sex: ___M ___F DOB: ___/___/_____ Age: ____ SS#: _____
Phone number: _____ Employer: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION

(If different than above)

Name: _____ Address: _____
City/State/Zip: _____
Sex: ___M ___F DOB: ___/___/_____ Age: ____ SS#: _____
Phone Number: _____ Employer: _____ Occupation: _____

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Financial Policy

Welcome! To ensure your treatments are as stress free as possible we have established a clear financial policy.

Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!

____ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated

____ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged and additional 35% to cover the cost of collections. (this amount will be added to you bill) *

I have read and understand the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party **Date**

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HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

Special Permission Request:

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine.

Initial: ____ Date: _____

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.

Initial: ____ Date: _____ Name: _____

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, LLC to revoke this release.

Signature: _____Date: _____