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Telehealth Weight Loss Registration Form

Please fill out form completely

Last Name:_____ **First Name:**_____ **MI:**_____

Social Security Number:_____ **D.O.B.**_____

Gender: Male/ Female/ Other **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

Home Phone:_____ **Cell/Mobile:**_____

Email address:_____

Home (Billing) Address:_____

City:_____ **State:**_____ **Zip:**_____

Patient Employed by:_____ **Occupation:**_____

Parent/Guardian Name:_____ **Relationship to Patient:**_____

Emergency Contact Info:_____
Name Phone Number Relationship to Patient

Based on government regulations, we are required to gather the following information:

Preferred Language:_____ **Ethnicity:** ☐Hispanic/Latino ☐Non-Hispanic/Latino

Race: ☐American Indian/ Alaskan Native ☐Asian ☐Black or African American ☐Caucasian ☐Other

Insurance Information:

Primary Insurance Company:_____ Co-Pay Amount:_____
Insurance ID/ Policy #:_____ Group #:_____
Insurance Holder Name:_____ Insurance holder DOB:_____

Secondary Insurance Information:

Secondary Insurance Company:_____ Policy Holder:_____
Insurance ID/Policy #:_____ Group #:_____

Medical History Information:

Patient Name:_____ **DOB:**___/___/___
Known Drug Allergies:_____
Sex: M / F Age:_____ Height:_____ Weight:_____
Date of last physical:_____ Date of last Menstrual Period:_____
Date of last Pap:_____ Date of last Mammogram:_____
Surgeries:_____

Have you ever had any chronic problems with the following?

	YES	**NO**	**EXPLANATION**
Ears, Nose, Throat			
Eyes			
Headaches			
Respiratory/ Lungs			
Joint (legs/Arms)			
Stomach/GI			
GYN (ovaries, Uterus, Cervix, Menstruation)			
Heart			
Bladder			
Kidneys			
Urination			
Blood Disorder			
Testicle / Penis			
Sexually transmitted disease			
Skin			
Mental Health (anxiety, depression, sleep problems, etc.)			

It Is Well Healthcare

MEDICATION LIST

Allergies to Medications:_____
Allergies to food:_____
Pharmacy:_____ City/Town:_____

Medication Name	Dose/ Strength	Times Per Day

Please list all doctors/specialists that you follow with below:

Social History Information

Please check all that apply:

Illness/Condition	Mother	Father	Sister	Brother	Grandmother	Grandfather	Describe
Cancer:							
Ulcers:							
Diabetes:							
Heart Disease:							
Prostate:							
High Blood Pressure:							
HIV:							
Breast:							
Heart Attack:							
Gallbladder disease:							
Stroke:							
TB:							
Migraines:							
Mental Illness:							
Thyroid:							
Asthma:							

Do you smoke?: YES or NO Number of cigarettes a day:_____
Do you drink alcohol?: YES or NO Number of drinks a day:_____
Week:_____

HIPAA

NOTICE OF PRIVACY PRACTICES

In accordance with the law, It Is Well Healthcare supports and upholds all matters pertaining to the privacy of your protected health care information. We will fully adhere to all legal requirements regarding your protected health care information, but reserve the right to change our privacy practices at any time as permitted by the law. If our privacy practices change, we will post a notice in our reception area, and provide you with a copy of the document changes.

CLIENT CONSENT FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I hereby consent to the utilization and disclosure of my protected health information by It Is Well Healthcare. In addition, I give my consent to provide treatment and secure payment, and other health care operations as related to my care. I have read/reviewed the Privacy Practice Statement (as above), prior to signing this consent, I understand that It Is Well Healthcare is required by law to report suspected or diagnosed child abuse and neglect; and conditions identified as " reportable conditions" by statue to the State Public Health Office.

It Is Well Healthcare may mail to my home, or other designated location, may correspond with me via telephone, leave verbal messages on my voicemail, or speak with me in person, in reference to any items or issues that will assist in the provision of my care, payment, and or other health care operations such as, insurance item, follow-up communication, X-ray and / or laboratory results, or other, pertaining to my care. This includes the transfer of my protected health information (if required) by postal mail, as long as the consents are addressed to me personally and are marked " personal and confidential" or are delivered by It Is Well Healthcare.

I further realize that I have the right to request that It Is Well Healthcare, restrict the use / disclosure of my personal health information regarding treatment, payment, and / or other health care operations or activities. However, It Is Well Healthcare is not required to agree to my requested restrictions. If It Is Well Healthcare does not agree to my requested restrictions; they are bound by the legal constraints regarding the privacy and protection of my health care information

I have read and understand the Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information

Print Name _____ **Date:** _____

Signature _____ **Date:** _____

It Is Well Healthcare

Patient Financial Responsibility

I (We) jointly and severally, agree to pay all of the charges for professional services rendered to the patient.
I (We) understand that these changes are in addition to charges by a hospital or other medical professional rendering services to the patient.

I (We) Promise to pay the charges in full at the time a bill is presented, unless other terms have been agreed to in writing. In the event prompt payment is not made, the undersigned understands that the account may be referred for collection. In such an event any unpaid balance shall accrue interest at the rate of 2% of the amount due. **We also use third-party vendors such as LabCorp, Quest, and Bayhealth for labs Imaging and studies. If you are self-pay and or your insurance does not cover these vendors you may receive a bill for their products and services in which you agree and would be financially responsible to pay these vendors directly.**

If the patient has provided insurance information, It Is Well Healthcare, LLC may, but it is not required to assist the patient in the filing of a claim.

I request and authorize that payment of authorized Insurance Company benefits may be made on my behalf to It Is Well Healthcare for any services furnished to or by this company. I authorize any holder of medical information about me to be released to any insurance company(s) any information needed to determine benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare / other insurance company assigned cases, It Is Well Healthcare agrees to accept the charge determination of the Medicare / other insurance company as the full charge, The patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare / other insurance company.

Patient Signature:_____

Responsible Party:_____

HIPAA CONSENT

I _____ authorize It Is Well Healthcare to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance company, and for health care operations like quality reviews. I authorize the persons listed below to give or receive any information via telephone, mail, or in-person which would be of benefit to my care or wellbeing. I am aware that It Is Well Healthcare will not be responsible for the handling of any information released to the persons that I have listed below.

_____	_____	_____
Name (First/Last)	Relation	Phone Number
_____	_____	_____
Name (First/Last)	Relation	Phone Number
_____	_____	_____
Name (First/Last)	Relation	Phone Number
_____	_____	_____
Name (First/Last)	Relation	Phone Number

_____ _____

Parent/Guardian/Patient Name (PRINT) Parent/Guardian/Patient Name (SIGN)

_____

Date

Medical Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to It Is Well Healthcare. When you schedule an appointment with It Is Well Healthcare we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation/no show policy below:

- Effective November 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a no show and charged a **$25.00 fee.**

- If a **fourth** no show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from It Is Well Healthcare.

- Any new patient who fails to show for their initial visit will not be rescheduled after 3 no shows.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, that above policy will remain in effect.

We understand that there may be times when an unforeseen emergency occurs and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our office, who may be able to waive the no show fee. You may contact It Is Well Healthcare at the number listed below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

It Is Well Healthcare (302-678-9355)

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____
Signature (Parent/Legal Guardian)	Relationship to Patient
_____	_____
Printed Name	Date