It Is Well
Healthcare

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(P) 302-678-9355 **(F)** 302-678-9310

New Patient 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.)			

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I authorize the above-named health care provider to release the information or records specified upon request in person or by mail to the address specified at the time of the request.

Previous Provider Name:_____**Phone #:**_____ **Fax #:**_____

Please release the information to: **It Is Well Healthcare** **29,31 and 33 Gooden Ave Dover, DE 19904** **(P) 302-678-9355 (F) 302-678-9310**	**Patient Name:** **DOB:**

Specific Information Authorized to be released:

☐ Medical Record from (insert date)____/___/_____ to ___/___/_____
☐ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.
☐ Other: _____

This information will be used for the purpose of the following as needed:

Investigating an allegation of abuse	Legal Representation
Other activities at the request of the individual	Providing advocacy services
Verifying my eligibility for services offered by	

* I understand that I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal
* Federal privacy regulations will no longer apply to the information disclosed and that It Is Well Healthcare may redisclose the information.
* I am entitled to received a copy of this authorization
* A copy of the authorization may be utilized with the same effectiveness as an original

_____

Signature of Patient or Representative **Date**

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:

It Is Well Healthcare

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:_____

It Is Well
Healthcare

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 2 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.**
- **Effective JULY 1st, 2024, Late Arrival Appointment Policy UPDATE. When we reserve time for you, we require all that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this. If you arrive late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If you call ahead to say you will be late, this does not alter the policy. We only allow a 5 (FIVE) minute window of time before you are considered to be a NO SHOW and you will be rescheduled.**
- 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

How did you hear about us? _____

NOTICE

By Federal Law and Managed Care Contract Law, this office is required to collect co-payment and deductible for each encounter.

PENALTY FOR NOT FOLLOWING THIS REQUIREMENT COULD RESULT IN THE TERMINATION AND CANCELLATION OF MEDICAL COVERAGE FOR THE PATIENT.

Our agreement with health insurance plans require us to collect co-payment and deductibles At the time services are rendered.

The Center for Medicare and Medicaid Services required that we collect co-insurances And deductibles from Medicare beneficiaries.

Please help us comply with these requirements by making your co-payments today. We Accept cash, check and all major credit cards.

Thank you !

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Patient Financial Responsibility Form/ Self-Pay Consent
** Please complete and sign this form if you are self-pay!

This is a fee for service / Self pay visit
It Is Well Healthcare Self-Pay rates are as follows….
$100.00 standard provider visit
$125.00 New Patient / Establishment appointment
$25.00 Nurse Visit

And will not be billed to your insurance (in the case that there is insurance)

Patient Name: _____

Date of Birth: _____

Date: _____

I attest that:

This Self-Pay Agreement is intended to provide patients and parents/legal guardians with an understanding of their financial responsibilities should they elect to self-pay for It Is Well Healthcare services.

By signing this agreement, I, _____
(patient or parent/legal guardian), understand and agree that:

1. I am not currently enrolled in or eligible for Medicare, Tricare, or Medicaid

2. I represent that (check appropriate box below
   - o I have health insurance coverage; however, It Is Well Healthcare does not currently accept my health insurance plan.
   - o I do not currently have health insurance coverage.

It Is Well, LLC Primary Care Policy for Patients with Outstanding Balances

***** NOT PERTAINING TO MEDICAID PATIENTS *****

1. Billing and Payment Expectations

Payment at the Time of Service: Patients are required to pay for services at the time of their appointment. Co-pays, deductibles, and any out-of-pocket expenses should be settled when checking in for your appointment.

Post-Service Billing:

If a balance remains after insurance processing, the medical office will send an invoice reflecting the amount due.

1. Three-Statement Billing Process:

- First Statement:

A detailed invoice of the patient's outstanding balance will be mailed or emailed within 30 days after services are rendered or insurance has processed the claim. This is considered the first notice of the balance due, and payment is expected within 30 days of receiving this statement.

- Second Statement (30 Days Past Due):

If payment is not received within 30 days of the first statement, a second statement will be sent, along with a reminder to pay the outstanding balance. Patients will have another 30 days to settle the balance or arrange a payment plan.

- Final Statement (60 Days Past Due):

If no payment or arrangement has been made within 60 days, a third and final statement will be sent. This final statement will clearly indicate that the account is overdue and must be paid within 15 days to avoid further action.

Payment Methods:

The following payment options are available to settle outstanding balances:

- Cash

- Credit/Debit Cards

- Personal Checks

- Online Payments via the patient portal

Failure to Pay After the Final Statement:

Additional Late Fees:**

A late fee of 5% may be applied to the outstanding balance if no payment or communication is received after the third statement.

- Service Suspension:

Future non-emergency services may be suspended until the account is paid for in full.

- Collections:

If the balance remains unpaid after the third statement (75 days past due), the account may be sent to a third-party collection agency. Patients will be notified before this action is taken, and further communication will be directed to the collection agency.

- Billing Inquiries:

Any disputes or concerns regarding the bill must be addressed within 30 days of receiving the first statement. The billing office will investigate and resolve any discrepancies.

Please call the office manager at 302-342-0004.

Patient Name: _____

Date: _____

Signature: _____

It Is Well, LLC Primary Care Rules and Regulations / Consent to Treat:

Please make sure the patient's insurance card and identification card are present during your appointment, along with any insurance co-pays.

Please notify the office immediately if your insurance changes and please bring us a copy of the new card for billing purposes.

We respectfully request a 24-hour advance notice if you need to re-schedule or cancel your appointment.

Children under the age of 18 must be accompanied by a parent / guardian. If someone other than the parent / guardian is present with the child, then a note from the parent / guardian must be written and present with the patient at the time of the visit giving permission for treatment on that day.

Please allow 24 to 48 hours for all prescription refills to be completed by the office. Please be sure to call in your refill requests to the office at least 3 Days prior to your last dose, this will help to prevent from being out of medication(s). Make sure to call your pharmacy before picking up the medication to make sure the prescription is ready.

If you are referred to a specialist or require any type of diagnostic testing and your insurance requires a referral /authorization, please notify the nurse, and please allow 24-48 hours for the office to complete the referral / authorization

Please initial on the line below if you allow the office to leave a message on your voicemail in regards to any appointment reminders (this includes but not limited to specialists, medication refills and / or radiography studies). Initials: _____

PERMISSION TO TREAT

I HEREBY AUTHORIZE IT IS WELL HEALTHCARE, LLC TO EVALUATE AND TREAT ME FOR MY PRESENTING CONDITION. I UNDERSTAND THAT THE PROVIDER EVALUATING ME MAY IN HIS/HER PROFESSIONAL OPINION, DETERMINE THAT I NEED TO BE TRANSFERRED TO A HIGHER LEVEL OF CARE SUCH AS THE EMERGENCY DEPARTMENT. I AGREE TO PAY FOR ANY AND ALL MEDICAL SERVICES RENDERED AT IT IS WELL HEALTHCARE LLC.

SIGNATURE:_____

PRINTED NAME: _____

DATE OF BIRTH: _____

RELATIONSHIP:_____ DATE:_____