Wake Internal Medicine Consultants, Inc.

WAKE SPORTS MEDICINE NONSURGICAL ORTHOPEDICS | Wake Women's Health | WAKE GASTROENTEROLOGY | Wake Internal Medicine & Pediatrics

PATIENT REGISTRATION

Chart: _____

Doctor: _____

Date: _____

Patient Information

Name: _____

Address: _____ Apartment No.: _____

City: _____ State: _____ Zip Code: _____

Telephone (Primary): _____ _____ (Secondary): _____

Cell Phone for receiving text messages: _____ Email: _____

Birthdate: _____ Sex: M F Marital Status: M S Other

Social Security Number: _____ Employer: _____

Please note that these questions are being asked in compliance with CMS Meaningful Use.

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Declines to Provide

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Declines to Provide

Language: ☐ English ☐ Other _____

Primary Physician *(if seeing GI or GYN doctor)*: _____

How did you hear about us? ☐ Physician Referral ☐ Family/Friend ☐ Other _____
☐ Insurance Carrier ☐ Direct Mailer ☐ Google ☐ WIMC Website ☐ Yellow Pages ☐ Yellowpages.com ☐ Internet

Person to contact in case of emergency? _____

Emergency Telephone: _____

Preferred Pharmacy and Location: _____

Preferred Method of Contact: ☐ primary phone ☐ mail ☐ email (patient portal-secure messaging)

Responsible Party

Party responsible for payment: Self Spouse Parent Other

Name (if other than Self): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Insured Party (Primary Card Holder)

Name: _____

SS# _____ DOB: _____

Are you interested in being contacted about participation in Research Studies? Yes No

See other side ☐

_____ Initials By providing us your email address you are consenting to the use of secure messaging and our patient portal.

CREDIT POLICY

_____ Initials Wake Internal Medicine will be happy to file claims to your insurance company as a courtesy to you. However, seeing that your account is paid is your responsibility. We do expect timely settlement of your account, and payment at the time of service is expected. Any delinquent accounts may be reported to the Credit Bureau.

ASSIGNMENT AND RELEASE

_____ Initials I, the undersigned, understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Wake Internal Medicine Consultants, Inc. to release all information necessary to facilitate the processing of all claims related to my care. I authorize use of this signature on all my insurance submissions.

MEDICARE PATIENTS ONLY

_____ Initials I acknowledge that I have been informed of Wake Internal Medicine Consultants non-participation with the Medicare Program and acknowledge that benefits will be paid to me unless other- wise prohibited by Medicare regulations. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I acknowledge my responsibility to pay the amount determined by Medicare to be my responsibility to Wake Internal Medicine Consultants, Inc. in full on the date the service is rendered or as soon there after as can be arranged by mutual consent.

PRIVACY POLICY

_____ Initials I hereby acknowledge receipt, before any medical services were provided, of a "Notice of Privacy Practices of Wake Internal Medicine Consultants, Inc." for protected health information. I acknowledge that I have been given the opportunity to ask any questions that I may have regarding such policy. I understand that WIMC may use or disclose personal health information relating to me for purposes of treatment, payment, and health operations as disclosed in the notice.

NO SHOW/LATE CANCELLATION POLICY

_____ Initials I acknowledge that Wake Internal Medicine reserves the right to charge a fee for missed appointments or procedures. A missed appointment is defined as failure to show for your scheduled appointment or a cancellation/reschedule within less than 24 hours of the appointment time slot (3 business days for procedures).

Patient Signature: _____

Print Name: _____

Date: _____