

Whole Life Health Care

Patient Information

Name(Last) _____ (First) _____ (MI) _____
Address _____ City _____ State _____ ZipCode _____
Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____
Cell/Other (_____) _____ Employer _____
Sex _____ Date of Birth ____/____/____ Social Security _____ - _____ - _____

If Patient is a minor, fill in the following:

Parent or Guardian #1: _____ Parent or Guardian #2: _____
Relationship _____ Relationship _____
Phone (_____) _____ Phone (_____) _____
Initial if you will allow this minor-patient to be treated at Whole Life Health Care without your presence _____

Emergency Contact _____ Phone (_____) _____
Relationship to Patient _____ Date of Birth ____/____/____

Primary Contact for Billing _____ Phone (_____) _____
Address _____
Relationship to Patient _____ Date of Birth ____/____/____

How did you learn about us? (Please check one) Word of Mouth (Who?) _____
 Internet Newspaper Yellow Pages Other (How?) _____

The following information will be found on your insurance card. We will also need to make a photocopy of your card:

Primary Insurance _____ ID# _____ Group # _____
Insurance is in whose name _____ Employer _____
DOB ____/____/____ Insurance Effective Date _____

Secondary Insurance _____ ID# _____ Group# _____
Insurance is in whose name _____ Employer _____
DOB ____/____/____ Insurance Effective Date _____

Please **read** and **sign** the back of this document.

**Whole Life Health Care
100 Shattuck Way Suite 100
Newington, NH 03801**

Payment Policy - Please read and sign below

- Whole Life Health Care has contracts with the following insurance companies: NH Blue Cross, Federal Blue Cross, Cigna of NH, Harvard Pilgrim, all Health Care Value Management companies, Medicare, NH and ME Medicaid, Aetna, and United.
- We will submit primary claims to all the contracted insurance companies listed above and all secondary and tertiary claims provided we contract with your primary insurance.
- If you have an insurance company that we cannot bill, you will be responsible for your charges when you are seen. If you are unable to pay for your visit at the time of service you may reschedule. We accept cash, checks, money orders, MasterCard and Visa.
- We do offer a 15% Quick Pay discount at the time of service for patients who pay for every visit, these would be patients who have no insurance or who have insurance that we cannot bill. If payment is not made by 5:00 p.m. the day of the service, or if you have a past due balance, we will not be able to give the 15% discount.
- We require that you bring your insurance card to each and every visit so that we may keep our records up to date and eliminate billing problems.
- Anthem and Harvard Pilgrim HMO patients: If Whole Life Health Care has not been selected as your Primary Care Office, you will be asked to sign a waiver stating that you will be responsible for any charges denied for this reason.
- Failure to respond to requests from your insurance company will result in the balance becoming your responsibility.
- Minor children are required to have a parent or legal guardian present at the time of their appointment, except for family planning, or no services will be provided and the appointment will be rescheduled. After the first visit we will accept a signed, dated note from the parent or legal guardian authorizing us to see and treat the minor patient.
- In cases of divorced or separated parents our policy is that the parent who brings the child in to the office must be responsible for any charges after insurance, if any, is billed.
- Co-pays are due prior to your appointment and will be collected upon arrival.
- Payment is due on all billed services within thirty (30) days unless prior arrangements are made with billing.
- If you are not able to pay for an upcoming visit you may make arrangements with billing prior to your appointment to set up a reasonable payment plan for full payment of the service.
- If your account has a past due balance over 90 days this balance must be paid prior to scheduling any future appointments. Your account may be sent to our collection agency if accounts are unpaid.
- 24 Hour notice is required when canceling appointments. If you fail to notify us in time, you may be subject to our Missed Appointment Fee of \$25.00. If you consistently miss appointments, you may be subject to dismissal from this practice.

I hereby authorize Whole Life Health Care to furnish information to my insurance carrier(s) concerning any illness and treatments and I hereby assign to Whole Life Health Care all insurance benefits for medical services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for any and all professional services rendered. I have read the information in this financial policy and I understand and agree to all of its terms.

I also authorize Whole Life Health Care, P.A. and its physicians, health care practitioners, employees and the subcontractors in collaboration with Whole Life Health Care, P.A. to have access to my medical records for the purpose of medical treatment / services within the Whole Life Health Care, P.A. facility.

* I hereby agree to consultation with Whole Life Health Care and agreed upon treatments.

Signature _____ Date _____

Parent Signature (if pt is minor) _____ Date _____

Whole Life Health Care

Notice of Privacy Practices

We are required by federal law to provide you with a “Notice of Privacy Practices.” This notice describes how health information that we maintain about you may be used or disclosed. It provides a description of your rights and our obligation under federal and state privacy laws.

The confidentiality of patient information has always been a high priority for us. Our employees are constantly reminded of its importance. This ethic will not change.

The Federal Government has recently passed a law – the Health Insurance Portability and Accountability Act (**HIPAA**). The law formally protects your Protected Health Information (**PHI**), which includes your demographics (address, phone number, etc.) and all your health information.

Under the law you have specific rights – subject to certain exceptions and limitations:

1. To receive a paper copy of this “Notice of Privacy Practices”
2. To request an amendment of the health information in your file, if you believe it is inaccurate. If your request to amend your health information is denied, you may submit a written statement to Whole Life Health Care disagreeing with the denial which we will keep on file and distribute with all future disclosures of the information to which it relates.
3. To an accounting of certain disclosures made by this office of your PHI made during the 6 yr. period preceding the date of your request. Exceptions include, disclosures regarding treatment, disclosures made to you as a patient, payment, or health care operations purposes: disclosures to your family or close friends involved with your care; or for notification purposes.
4. To examine and copy your protected health information. To arrange access to your records or to receive a copy of your records a written request should be submitted to our privacy officer or to the medical records office.
5. To request restrictions, other than regarding emergency circumstances, on the allowable uses and disclosures of your PHI. Such restrictions may include prohibitions on disclosure of certain types of PHI or certain persons you do not wish to have access to your PHI. Whole Life Health Care is not required to agree with these restrictions. To request a restriction, submit a written request to our privacy officer.

Whole Life Health Care in compliance with the privacy law:

1. May use your PHI, without separate consent or authorization from you for treatment, payment or facility operations in connection with services rendered by us, to you. For example we may provide your past medical history to a consultant you’ve been referred to or we may provide your personal health information to your insurance plan or to support our request for reimbursement. We may also, with your consent, disclose your PHI to family members and close friends involved in your care.

2. May be required to disclose your PHI, without your consent or authorization, if required by law. For example, the law requires that certain PHI be disclosed in connection with protection of the public health, for governmental health oversight activities, in response to a valid subpoena or other judicial process, in response to certain law enforcement inquiries, or to lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures other than those specifically referenced above or otherwise allowed by law, will be made only with your written authorization and you may revoke such authorization, in writing, at any time.

It is our policy to contact patients by phone to provide appointment reminders. A message about the appointment reminder may be left on your answering machine or on your work voice mail. Results of strep screens may also be left on your answering machine or voice mail.

Marketing Materials: You will not receive any marketing materials from us, unless we first receive a separate written consent form, executed by you, allowing us to provide you with such information.

Changes to the Notice: This facility may change the terms of this written notice and may make the new notice provisions effective for all protected health information that we maintain. If we do so, we will provide you with a copy of the revised notice upon request, and we will post the notice, with the effective date, in a visible location in this office. This notice may at some point in time also be posted on our website.

Complaints: If you believe your privacy rights have been violated you may complain to us and to the Secretary of the United States Department of Health and Human Services. If you have any questions about this, or wish to file a complaint with this office, please file a written complaint with our designated privacy officer. You will not be retaliated against in any way for the filing of the complaint.

Designated Contacts:

Erin Hammond
100 Shattuck Way Suite 100
Newington, NH 03801
603-431-6677

Whole Life Health Care – Family Practice

Notice of Privacy Practices Signature Form

In compliance with the Federal Law regarding patient’s privacy, we ask you to please read the “Notice of Privacy Practices” and sign this form.

* * * * *

I _____ a patient of Whole Life Health Care – Family Practice, acknowledge that I received and read the “Notice of Privacy Practices”.

Patient Signature

Date

* * * * *

I _____ the parent / guardian of _____, Date of Birth _____ received and read the “Notice of Privacy Practices” of Whole Life Health Care – Family Practice.

Parent / Guardian Signature

Date

Whole Life Health Care Family Practice

100 Shattuck Way
Newington, NH 03801
603-431-6677 (phone) * 603-610-2232 (fax)
www.mywholelifehhealthcare.com

I, _____, DOB: _____,
(patient name)

give Whole Life Health Care Family Practice permission to speak with and/or release information about my
medical care and treatment to:

_____, who is my _____
(name) *(relationship to patient)*

This release of information will be valid unless Whole Life Health Care is notified by patient.

* * * * *

Patient Signature

Date:

Whole Life Health Care - Family Practice

Medical Records Authorization to Release or Request Healthcare Information

100 Shattuck Way, Suite 100, Newington, NH. 03801
Phone: 603-431-6677 Fax: 603-610-2232
www.mywholelifehealthcare.com

Patient Name _____ Date of Birth _____

Office or Person **Releasing** Medical Record Information:

_____ Phone _____ Fax _____

Address _____

Office or Person to **Receive** Medical Record Information:

_____ Phone _____ Fax _____

Address _____

Medical Record Information will be (please check one):

- Picked up by Patient Please mail to receiving office/person
(*please note you may be charged a shipping and handling fee)

Information to be released (please check all that apply):

- Complete Medical Record Treatment Records / Progress Notes
 Last Annual Exam and Pap Test Laboratory Tests
 Immunization Records Diagnostic Tests (X-Rays, CT Scans, MRIs)
 Other: _____

I understand that the information I have agreed to release may include but is not limited to sensitive information such as: sexually transmitted disease, AIDS, HIV, behavioral or mental health services, alcohol drug abuse treatment, sexual preference, counseling/family problems. I agree to its release. If you DO NOT WANT this information released please specify what information should NOT be released:

To help improve our patient care, please let us know the reason you are requesting these medical records:

- Personal Copy Moving out of area Insurance Purposes
 Second Opinion Dissatisfied with Provider Legal Purposes
 Sharing Care with Specialist Transferring / Other, please describe: _____

I understand that:

- ~I can see and copy the health information described above.
~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
~Under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.
~ Consent expires one year from date signed

Patient / Legal Guardian Signature _____ **Date** _____

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