Baxter Drew Wellmon II DO
Nathan Petula PA-C
Samantha Stuby PA-C
Valerie Goates PA-C
93 Progress Boulevard, Suite 1
Shippensburg, PA 17257
Tel: (717)-532-3211 Fax: (717)-532-3099

PATIENT INFORMATION FORM

Last Name:	Social Security Number:
First Name: Middle Initial:	Date of Birth:
Home Address:	Age: Sex:
Home Address 2:	Home Phone:
City, State, Zip:	Cell Phone:
Patient Employer:	Work Phone:
Race: Caucasian - African American - Asian - Native American	Ethnicity: Hispanic/Latino- Other
Marital Status: Single Married Divorced Widowed	Pharmacy:
Spouse Name:	Email:

EMERGENCY CONTACT INFORMATION: IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

Name:	Telephone #:

PRIMARY INSURANCE

Plan Name:	Subscriber ID/Policy #:
Plan Telephone:	Group #:
Subscriber Name:	Subscriber Date of Birth:

Relationship to patient (please circle) Self Wife Husband Parent Other

SECONDARY INSURANCE

Plan Name:	Subscriber ID/Policy #:
Plan Telephone:	Group #:
Subscriber Name:	Subscriber Date of Birth:

Relationship to patient (please circle) Self Wife Husband Parent Other

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to: Baxter Drew Wellmon II DO for services rendered. I also authorize the release of any medical information necessary to process my insurance claims. I request and authorize that payment/insurance benefits be made directly to Baxter Drew Wellmon II DO for any services furnished to the above named patient by Baxter Drew Wellmon II DO. The signature below shall suffice for all insurance forms on continuing basis. I agree to pay Baxter Drew Wellmon II DO for all charges for services not covered by Insurance Payer.

Patient or authorized persons signature:________________________________ **Date:**____________

Failure to notify office regarding cancellations 24 hours before appointments will result in a $25 charge.
Returned checks will be subject to a $35.00 charge.

MEDICAL HISTORY FORM

patient name:	DOB:	date:

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ high blood pressure
- ☐ high cholesterol
- ☐ heart problems
- ☐ rheumatic fever
- ☐ stroke/CVA/TIA
- ☐ anemia
- ☐ prior blood transfusion
- ☐ blood clots/DVT
- ☐ tattoos
- ☐ diabetes
- ☐ thyroid problems
- ☐ emphysema/COPD
- ☐ asthma
- ☐ urinary incontinence
- ☐ stomach ulcers/reflux
- ☐ colitis
- ☐ depression
- ☐ anxiety
- ☐ epilepsy/seizures
- ☐ headaches
- ☐ skin problems/psoriasis
- ☐ cancer
- ☐ leukemia
- ☐ HIV/AIDS
- ☐ other significant illnesses:

previous surgeries/operations:

____

____

specialists you have visited in the last year (note that these records may need to be requested separately):

____

SOCIAL HISTORY

Do you use tobacco products? ☐ yes ☐ no ☐ past—how long ago? ____________ form____________

drink alcohol? ☐ yes ☐ no ☐ past number per week or day ____________

use drugs for reasons that are not medical? ☐ yes ☐ no if yes, please list:____________

drink caffeinated beverages? ☐ yes ☐ no cups/glasses per day: ________

exercise regularly? ☐ yes ☐ no

get enough restful sleep at night? ☐ yes ☐ no hours/night: ________

work/occupational history: ______________________________

☐ disabled? Please explain:______________________________

FAMILY HISTORY *for immediate family members (parents, siblings)*

- ☐ diabetes
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ heart disease
- ☐ stroke
- ☐ cancer
- ☐ mental illness
- ☐ other

MEDICATIONS

current medications: ______________________________

____

____

____

supplements or natural/alternative therapies: ______________________________

____

____

allergies to medications: ______________________________

other allergies: ______________________________

PATIENT PRIVACY INFORMATION

Patient Name:	
DOB:	Date:

Would you like to make your health information available to any other person(s). This could include your family, a relative, close friend, or any other person involved in your health care.

☐ No, I do not authorize consent to release my protected health information (PHI).

☐ Yes, I authorize consent to release protected health information (PHI) available to the following person(s) below:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Authorization to leave appointment information on:

☐ **Answering machine?**	☐ **Office/work voicemail?**	☐ **With another person?**
Other person name:	Tel Number:	

Authorization to leave medical information on:

☐ **Answering machine?**	☐ **Office/work voicemail?**	☐ **With another person?**
Other person name:	Tel Number:	

Patient / Legal Guardian Name: ____

Patient / Legal Guardian Signature: ____

HIPPA Consent to Use and Disclose Health Information

I hereby consent to the USE AND/OR DISCLOSURE of my identifiable health information by Wellmon Family Practice in order to carry out treatment, payment, and healthcare operations as defined by the Health Insurance Portability and Accountability Act of 1996, at 45 CFR Parts 160, 103, and 164.501. I understand that the privacy of my health information is under protected under State and Federal laws. I acknowledge my right to receive and to review a Notice of Privacy Practices, and affirmed that I have received a copy of the Notice of Privacy Practice prior to executing this Consent.

I understand that Wellmon Family Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If the Notice of Privacy Practices is changed, a general notice will be posted in certain common areas of Wellmon Family Practice. I may obtain a copy of the revised Notice of Privacy Practices by submitting a written request to Wellmon Family Practice at 97 Progress Blvd, Ste 1, Shippensburg, PA, 17257, or by calling (171) 532-3211.

I retain the right to request that Wellmon Family Practice restrict how my health information is used or disclosed in the course of carrying out treatment, payment, and healthcare operations. I understand that such requests must be made in writing and must be submitted to Wellmon Family Practice. Wellmon Family Practice is not required to agree to such restrictions. However, if Wellmon Family Practice does agree to my requested restrictions, such restrictions will be binding upon Wellmon Family Practice.

I understand that I retain the right to revoke this Consent at any time. This revocation must be made in writing, and must be submitted to the Wellmon Family Practice at 97 Progress Blvd, Ste 1, Shippensburg, PA, 17257. This written revocation will become effective upon receipt.

I understand that any restriction of this consent may result in the inability for Wellmon Family Practice to continue to provide further treatment to me. Further, I understand that Wellmon Family Practice may refuse to treat me if I, or my authorized representative, do not sign this Consent, except to the extent that such treatment is required by law.

I affirmed that I have read and understand this information in that I have received a copy of this Consent form.

______________________________   ______________________________
Signature   Date   Authorized Representative

______________________________   ______________________________
Print Name   Print Name and Relationship

Failed to Obtain Consent, but Use And/Or Disclosure of health information allowed for:

____

____ Emergency
____ Treatment required by law
____ Substantial Barriers to Communication

Witness

____
Print Name

Refused to sign or obtain consent ________

Wellmon Medical Associates Financial Policy

Thank you for choosing the team at Wellmon Family Practice as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our policy and ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Payments, Co-payments and deductibles. Payment is required at the time of service. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Invoices must be paid within 30 days

3. Claim rejections and Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered. Services may not be considered reasonable or necessary by your insurance carrier. Payment is expected in full for all services, even if they are denied by your insurance carrier.

4. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays or approves your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you

7. Nonpayment. If your account is over 90 days past due, unpaid balances will be sent for collection. If your account goes into collection 3 times, it will be an automatic discharge from practice. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $25 for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Missed appointment fees are not covered by insurance or Medicare. If you have 3 cancellations/rescheduled appointments, you will be discharged from our practice. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Address, phone number and contact information. Changes in address, phone number, or any other contact information for patients and guarantors must be made within 30 days during which charges are outstanding. Returned statements due to incorrect address will be charged a $2.50 statement fee for each returned statement.

10. Returned Checks. Additional fee of $35

I agree to abide by the financial policy stated above:

Printed Name:________________________________ **Signature:**_________________________ **Date:**___________

MEDICAL RECORDS RELEASE FORM

incoming

Wellmon Medical Associates
Baxter Drew Wellmon, II D.O.
Nathan Petula, PA-C, Samantha Stuby, PA-C, Valerie Goates, PA-C

Name of Patient:______________________________ Date of Birth: ____/____/_____

I authorize the release of my medical record from the following medical provider(s):

____

Address: ____

____

____

telephone:______________________ fax:__________________________

to be sent to:

Wellmon Medical Associates
93 Progress Blvd, Shippensburg, PA 17257
Phone: (717) 532-3211, Fax: (717) 532-3099

Medical Information Requested:

- ☐ Entire record
- ☐ Specific time period: records from ______ to______
- ☐ Labs
- ☐ X-rays and other studies
- ☐ Other: ____
- ☐ Exclusions: ____

Please note: records from specialists will need to be requested separately

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. The release of my records is for continuation of care, and no personal information will be sold or used for marketing purposes by a third party. This document is to expire six (6) months from date of signature.

Patient's signature: ______________________________ Date: ___/___/______

The Confidentiality of HIV-Related Treatment Information Act requires separate permission.

- ☐ I consent to disclosure of information regarding HIV diagnoses and treatment.

Patient's signature: ______________________________ Date: ___/___/______

Witness signature: ______________________________ Date: ___/___/______