PATIENT DEMOGRAPHICS Woodrome Medical PA

Name:_____ **DOB:**____/____/____ **Chart Number:**_____

Sex: ☐ M ☐ F Marital Status: ☐ Single☐ Married☐ Widowed☐ Divorced **SS#**_____-_____-_____

Email:_____

Address:_____ **City:**_____ **State**____ **Zip**_____

Home #:_____ **Cell #:** _____ **Other #:**_____

Occupation:_____ **Employer:**_____ **Phone:**_____

EMERGENCY CONTACT **Name:**_____ **Phone #:**_____

Ethnicity/Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other_____

Privacy Information Preferences

Have you completed any advanced directives? ☐ Y ☐ N Does anyone have Medical POA over you ☐ Y ☐ N

Do you want to exempt from public reporting? ☐ Y ☐ N Can we send mail to the address listed on file? ☐ Y ☐ N

Can we call the phone number on file? ☐ Y ☐ N Can we leave a voicemail on machine? ☐ Y ☐ N

Who can we leave messages with? ☐Spouse ☐ Parent ☐ Child ☐ Other_____ Name:_____

How did you hear about out office? ☐ Physician ☐ Website ☐ Phonebook ☐ Family ☐Friend ☐ Other _____

Primary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

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

Secondary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

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

PLEASE READ AND SIGN

The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process the claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I Authorize the Doctors office to retrieve my medication history.

Patient Signature: _____ Date: ____/_____/_____

Woodrome Medical, PA

Assignment of Benefit, Consent to Treat, AI, Preventive and Diagnostic Labs

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Woodrome Medical, PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Consent for Treatment:

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant and advance practice nurse for my health care needs.

AI Scribe during Medical Encounters

Your participation is completely voluntary. If you have any questions or concerns, please feel free to discuss them with us.

Preventive and Diagnostic Labs

A wellness exam is a scheduled medical evaluation of an individual that focuses on preventive care. It will include an age and gender specific history, an examination, a review of risk factors and the ordering of appropriate immunizations, screening labs or diagnostic procedures.

A preventive exam is a periodic exam that covers all prevention and health maintenance issues related to age, sex and family history; it is a Well Exam. A preventive exam is NOT a follow-up visit or problem-based visit. A preventive exam cannot be expected to address all that has been bothering you since your last medical exam. Depending on the judgment of the provider, new problems or chronic disease follow-up may be addressed as a SECOND service during the visit or the provider may ask you to make another appointment.

Note

If a follow-up visit, discussion of any chronic disease, or new problem is discussed during your preventive visit, a follow up visit will also be charged with your well visit and you will be required to pay your copay or pay towards your deductible if so dictated by your insurance policy. Please consult with your insurer or HR department to understand your insurance coverage benefits and requirements.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. This order will remain in effect until revoked by me in writing.
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Date: _____ Patient Name: _____
Patient's Date of Birth: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received **Woodrome Medical PA** ***Notice of Privacy Practices*** or to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

PRINTED NAMES & PHONE NUMBERS of people that confidential information can be released to:

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed:
Patient Name:_____ Date of Birth:_____

CIRCLE ONE:
Patient or Legal Representative

_____
Signature

_____ Date:_____
Printed Name

If Legal Representative, relationship to Patient:_____

Woodrome Medical, PA
Patient Controlled Substance Agreement

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the controlled substance treatments we use. In this regard, we may refer you to a Pain Management program to ensure you have access to the best, safest treatments available. If your controlled substance medication (pain, stimulant, sedative) requires ongoing prescriptions that have significant addiction potential we will be requesting you to see a s specialist as applicable. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.
I, understand that I am being prescribed controlled substance; therefore, I must adhere to the following restrictions. Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.

1. I will not use alcohol/illegal drugs while being prescribed medication(s).
2. I will not take any other prescribed medications without first notifying my doctor.
3. I will notify my doctor immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms and immediate care center). Legally, failure to do so is a crime (obtaining or attempting to obtain drugs by fraud and/or deceit) and may be reported to the Police.
4. I will submit to random urine and/or serum drug screens as ordered.
5. I will only fill prescriptions for controlled substance at the pharmacy listed below. I will inform my doctor of any plans to change pharmacy. I will not obtain controlled substances from more than one pharmacy at a time. The only exception will be for acute need outside of the local area. I will authorize my doctor to communicate with my pharmacist.
6. I authorize my doctor to communicate with all physicians I have seen.
7. I understand it is illegal to share this medication.
8. I agree to keep my medication safe and secure in order to prevent loss or theft.
9. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
10. I understand that some of these medications may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment. I understand that overdose of this medication may cause death.
11. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications. I understand and accept the risk of addiction that can occur with this medication.
13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms or at their request.
14. (Y or N) Have you received any prescription medications from any other physician in the past thirty days? If yes, please list physician and medication below.

Physician: _____ Phone Number _____
Medication(s): _____

15. I understand I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be responsible for any costs this may incur.
16. I waive my right of privacy and authorize my doctor to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).
17. No refills will be authorized on weekends, holidays or after office hours. An exception may be made at the doctor's discretion if you are seen for an office visit with a copy of a completed police report.
18. Only the person for whom the official (previously known as triplicate) is written may retrieve the prescription.

Patient Name (PRINTED)_____ Date _____

_____ _____
Date of Birth Patient Signature