WOODROME MEDICAL, PA
REGISTRATION FORM

(Please Print)

Today's Date	Date of First Office Visit

PATIENT INFORMATION

Patient's Last Name	First	MI	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth ___/___/___	Social Security # ___-___-___	Driver's License #
Preferred Language	Race	Ethnicity

Spouse's Last Name	First	MI	Social Security #	Date of Birth:
Responsible Party's Last Name	First	MI	Social Security #	Date of Birth:

Street Address	Home Phone	Cell Phone

City	State	Zip Code	Email Address

Occupation	Employer Name & Address	Employer's Phone

How did you hear about us? ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family Friend ☐ Close to Work/Home ☐Other

Name of Pharmacy	Pharmacy Phone #	Name of other family members seen here

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to Patient	Phone #	Alternate Phone #

NOTICE & CONSENT

You have the right, as a patient, to be informed about your condition(s) and the recommended medical treatment(s) to be used so that you may make the decision whether or not to undergo the treatment(s) or procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment.

- I voluntarily request _____ as my provider, and such associates, technical assistants and other health care providers as they may deem necessary, to render primary healthcare services.
- I voluntarily consent to and authorize my healthcare services to be rendered by the above-named healthcare provider.
- I understand my provider may discover other or different conditions which require additional or different procedures than those planned. I authorize my provider, and such associates, technical assistants and other health care providers to perform such other treatment or procedures which are advisable in their professional judgment.
- I understand no warranty or guarantee has been made to me as to the results of my treatment or cure.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
- I have been given, or I will be given, an opportunity to ask questions about my condition(s), procedure(s) to be used, or treatment to be provided, and the risks and hazards involved. I believe I have sufficient information to give informed consent.

Patient/Guardian Signature Date

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Woodrome Medical, PA.

I understand that I am financially responsible for any balance. I also authorize Woodrome Medical, PA to release any information required to process my claims

Patient/Guardian Signature Date

Woodrome Medical, PA
Health Assessment Form Page 1

Please fill out to the best of your ability

Are you allergic to any medications? ☐ Yes ☐ No **If answer is yes, please describe below:**

Medication Name	Describe the reaction (i.e. hives, rash, etc.)

Please list all medications you are currently taking (please include over-the-counter, supplements & contraceptives):

Medication Name	Strength/Dosage	Frequency	Reason Why?

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any illnesses below by checking the box.

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
AIDS or HIV			Hepatitis (type _____)		
Anemia			High Blood Pressure		
Alcoholism			High Cholesterol		
Allergies (not medication)			Hernia		
Anorexia / Bulimia			Kidney Disease / Failure		
Appendicitis			Liver Disease		
Arthritis			Lung Disease		
Asthma			Measles		
Cancer (type_____)			Migraines		
Chemical Dependency			Mononucleosis		
Chicken Pox			Mumps		
Cataract			Pneumonia		
Depression			Psychiatric Care		
Diabetes			Rheumatic Fever		
Esophageal Reflux			Rubella		
Emphysema / COPD			Ovarian Cysts		
Epilepsy / Convulsions			Stomach Ulcer		
Frequent Kidney/Bladder Infections			Sexually Transmitted Disease		
Frequent Lung Infection			Stroke / Min Stroke		
Gallbladder Disease / Gallstones			Thyroid Problems (type_____)		
Glaucoma / Eye Disease			Tonsillitis		
Gout			Tuberculosis		
Heart Disease			Whooping Cough		

SURGICAL HISTORY: Please list any other operations, hospitalizations, or procedures you have had with date (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian_____ **Date**_____

Woodrome Medical, PA
Health Assessment Form Page 1

Please fill out to the best of your ability

FAMILY HISTORY: Please indicate if your blood relatives have had any of the following

Illness	Relation	Illness	Relation
AIDS or HIV		Glaucoma / Eye Disease	
Arthritis		Heart Disease	
Asthma		High Blood Pressure	
Bleeding Disorder		Kidney Disease	
Bowel Disease		Lung Disease	
Epilepsy / Convulsions		Psychiatric Care	
Chemical Dependency		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer (type _____)		Other ?	

SOCIAL HABITS: Have you used any of the following?

Substance	Check One	Amount Per Day?	For How Long?	When Stopped?
Alcohol	☐ Yes ☐ No			
Tobacco Products	☐ Yes ☐ No			
Caffeine	☐ Yes ☐ No			
Street Drugs (type _____)	☐ Yes ☐ No			

Are you sexually active? ☐ Yes ☐ No **How many partners have you had in the last year?**_____
Do you exercise safe sex precautions? ☐ Yes ☐ No **Would you like info on safe sex precautions?** ☐ Yes ☐ No

PREVENTATIVE: Please indicate the last time you had the following test/vaccine (MM/YY). Please note some are age dependent.

Exam	Date	Result?	Vaccine	Date
Cholesterol Testing			Tetanus/Diptheria/Whooping Cough Booser	
Eye Exam with Dilation			Flu Vaccine	
Colonoscopy			Hepatitis B Vaccine	
Tuberculosis Testing			Pneumonia Vaccine	
Stool Occult Blood Testing			Shingles Vaccine	
Males Only: Prostrate Exam			HPV Vaccine	
Males Only: PSA Level				

FEMALE PATIENTS ONLY - GYNECOLOGICAL HISTORY: Please answer the below questions if they are applicable for you.

Test / Exam	Date	Results	Performed By?
Pap Smear			
Clinical Breast Exam			
Mammogram			
Osteoporosis DEXA Scan			
STD and HPV Testing			

Age of onset of menstrual cycle _____ **Are they regular each month?** ☐ Yes ☐ No
Age of onset of menopause _____ **Hysterectomy?** ☐ Yes ☐ No **Have you taken estrogen therapy?** ☐ Yes ☐ No
Preferred Method of Contraception? _____ **Have you ever had an IUD?** ☐ Yes ☐ No
Tubal Ligation? ☐ Yes ☐ No **Number of Pregnancies** _____ **Number of Live Births** _____ **C-Section** ☐ Yes ☐ No
Have you had any miscarriage or complications with pregnancies or deliveries? ☐ Yes ☐ No
If yes, please explain:_____

Signature of Patient or Guardian_____ **Date**_____

WOOODROME MEDICAL, PA

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the ndividual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Woodrome Medical, PA

PHYSICIAN ASSISTANT / ADVANCE PRACTICE NURSE
CONSENT FOR TREATMENT

This facility has on staff a physician assistant and advance practice nurse ("APN") to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

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

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

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

I understand that at any time I can refuse to see a physician assistant or nurse practitioner and request to see a physician.

Patient Name:	Date
Signature:	Witness:

Woodrome Medical, PA

PREVENTIVE AND DIAGNOSTIC LABS

I am aware that any labs performed are labs that either my physician feels are needed for evaluation or that I am requesting. If my insurance denies payment of the labs, I realize I may be responsible for the cost. I understand Woodrome Medical, PA verifies coverage for my office visit but are unable to verify coverage for labs. I understand if my insurance does not cover the labs drawn I will receive a bill from the lab and I will need to contact my insurance and laboratory to arrange payment or for any questions.

Patient/Guardian Signature:_____

WHAT IS A PREVENTIVE EXAM?

Also Called a "Physical", "Wellness Exam" or "Annual Exam":
A preventive 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.

What Does This Mean?
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.

A Second Service May Be Necessary:
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. Examples of chronic diseases or problems that are not considered preventive care are diabetes mellitus, hypertension, heart disease, emphysema, chronic pain, gout, etc.

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.

Date:_____

Patient's Name:_____

Patient's Date of Birth:_____

Patient/Guardian Signature:_____

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 ,_____ which is a 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.

Pharmacy: _____Phone:_____
Address/Location:_____

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.

Woodrome Medical, PA
Patient Controlled Substance Agreement

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, In the event that the patient is unavailable please list designee below.
Designee will be required to show picture identification._____
I read the above, asked questions and understand this agreement. If I violate this agreement, I know the physician may discontinue my treatment.

_____	_____
Patient Name (PRINTED)	**Date of Birth**
_____	_____
Patient / Legal Guardian	**Signature Date**
_____	_____
Physician Signature	**Date**

Woodrome Medical, PA
Assignment of Benefits Form

Financial Responsibility:
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.

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.

Authorization to Release Information:
I hereby authorize Woodrome Medical, PA to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated in the course of examination and treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from Woodrome Medical, PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

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.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date