

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 our 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: _____

Signature

CIRCLE ONE:
Patient or Legal Representative

Printed Name

Date: _____

If Legal Representative, relationship to Patient: _____