WHOLE-HEALTH

AN INTERGRATED MEDICAL PRACTICE

NEW PATIENT REGISTRATION

Name:_____ Date of Birth: _____

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

Home Phone: (_____) _____-_____ Work Phone: (_____) _____- _____

Mobile: (_____) _____ - _____ Email Address:_____

Marital Status:_____ Social Security: _____ - _____ - _____ Age: _____ Sex: M / F

Emergency Contact. _____ Telephone: (_____)_____ - _____

Employer: _____

Occupation:_____

Please tell us how you heard about us:_____ ***Referred by*** _____

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

Relationship of Policy Holder to Patient?: Self_____ Spouse_____ Parent_____

Other_____

PRIMARY INSURANCE:

***IF SOMEONE OTHER THAN THE PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*

Plan Name: _____ Plan Type:_____

Insured's Name:_____ Insured's Birth Date:_____

Policy ID #:_____ Group # :_____

Claims Address & Phone:_____

Is this problem related to a **Motor Vehicle Accident: Yes / No**

If you answered Yes to the above, please complete the following information:

PIP Carrier:_____ Phone_____

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

Adjuster's Name: _____ Claim # : _____ Date of Injury: _____

Attorney Name:_____ Phone:_____

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

SIGNATURE:_____

WHOLE-HEALTH

AN INTERGRATED MEDICAL PRACTICE

CURRENT PHYSICIAN(S):

NAME:	SPECIALTY:	PHONE#:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALCOHOL USE: YES _____ NO _____

TYPE _____

FREQUENCY _____

TOBACCO USE: YES _____ NO _____

TYPE _____

FREQUENCY _____

FAMILY MEDICAL HISTORY:

ILLNESS	AGE	RELATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL RELEVANT INFORMATION:

_____

_____

_____

SIGNATURE: _____

WHOLE-HEALTH

AN INTERGRATED MEDICAL PRACTICE

PAST MEDICAL HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICATIONS:

	NAME	FREQUENCY	DOSAGE
1.			
2.			
3.			
4.			
5.			
6.			

DRUG ALLERGIES: _____

PAST SURGERIES:

PROCEDURES	YEAR

SIGNATURE: _____

Notice of Privacy Pratices

This notice describes how medical information about you may be used and disclosed by Whole Health, LLC and how you can get access to this information. Please read carefully.

What is This Notice and Why is it Important?

Each time you visit our office a record of your visit is made. Typically this record contains a description of your symptoms, medical history, exam and test results, diagnoses, treatment, and a plan for future care. This information is referred to as your medical record. This information serves the following:

- A basis for planning your care and treatment
- Serves as a means of communication among healthcare professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or your insurance company can verify the services you received were appropriately billed
- A tool with which we can assess and work to improve the care we provide

Your Health Information Rights

You have the following rights related to your medical and billing records kept:

- **Obtain a copy of this notice**. You may request a copy of your records at any time by contacting our office.
- **Authorization to use your health information**. Before we use or disclose your health information other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future disclosure.
- **Access to your health information**. You may request a copy of your health information that we keep in your medical or billing record. Your request must be submitted in writing. We may charge a fee for the costs involved in providing you access and for your copies.
- **Amend your health information**. If you believe the information we have about you is incorrect or incomplete, you may request that we correct the information. Your request must be in writing.
- **Request confidential communications**. You may request that when we communicate with you about your health information, we do so in a specific way (i.e. at a certain mailing address, email or phone number). We will make every reasonable effort to comply with your request.
- **Limit our use of your health information**. You may request that we restrict the use or disclosure of your health information for treatment, payment, healthcare operations, or any other purpose except when specifically authorized by you, when we are required by law or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we

believe your request would interfere with our ability to treat you or collect payment for our services.

- **Accounting disclosures**. You may request a list of disclosures of your health information that we have made for reasons other than treatment or payment of healthcare operations.

Other Responsibilities

We are required by law to protect the privacy of your healthcare information, establish policies and procedures that govern the behavior of our staff and business associates and provide this notice about our Privacy Practices and abide by the terms of this notice. We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. Except for purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

For More Information or to Report a Problem

If you believe we have not properly protected your privacy, have violated your privacy rights or you disagree with a decision we have made about your rights, you may contact our office directly

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I, the **Patient** have read and understand the terms of the Notice of Privacy Pratices provided to me and hereby consent to said terms.

Patient Signature:	Date:

Notice of Freedom of Choice

I the Patient understand that Whole Health, LLC is an independently owned company that provides medical services. Physicians and other licensed medical providers may be contracted as independent contractors or employed by Whole Health, LLC to provide care.

If I have been referred to Whole Health, LLC by another service provider, I am aware and acknowledge that I have the freedom to decline or choose services as I desire. I have the right at any time to decline services and/or seek another service provider and I understand that I will not receive any difference in treatment or services rendered.

I, the **Patient** have read and understand the terms of the Notice of Freedom of Choice provided to me and hereby consent to said terms.

Patient Signature:	Date:

Irrevocable Assignment of Benefits

PATIENT NAME: _____

_____	_____
Insurance Company #1 Name	Insurance Company #2 Name
_____	_____
Policy Number	Policy Number
_____	_____
Address	Address

I, _____ (Name of Patient), assert that my Social Security Number is, _____, and hereby irrevocably assign and transfer to Whole Health, LLC (the "Assignee"), which is located at 1705 S Federal Hwy, Suite A-4, Delray Beach, FL 33483 , its successors, agents and assignees the full right to any and all insurance benefits which are or may become due to me, together with any and all actions, causes and action, suits, debts, sums or money, accounts, covenants, contracts, promises and interest in, or which I might acquire an interest against _____ (Name of Insurance Carrier), in accordance with its obligations to me arising under a certain policy of insurance (under which I am either the insured or a covered dependent) for hospital, medical, chemical or substance abuse dependency services and other health care services rendered to me by the Assignee and I hereby indemnify and hold the Assignee harmless against any and all claims that have arisen or may arise with respect to the subject matter of this Irrevocable Assignment.

I also hereby further agree that I have no ownership interest in any insurance check(s) issued by the insurance carrier for payment of the services that were provided by Whole Health, LLC and that I have irrevocably assigned any ownership interest in these funds to Whole Health, LLC, as well as have authorized Whole Health, LLC all rights to appeal, communicate and provide any other service required to obtain reimbursement from my insurance carrier.

I hereby authorize and request your Company to pay directly to Whole Health, LLC, the amount due me in any claim for services rendered to me.

_____ Date: _____
Signature
Printed Name: _____

_____ Date: _____
Witness
Printed Name: _____

WHOLE-HEALTH
Private Family Practice and Urgent Care

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ DOB:_____

I understand and agree that it is my responsibility and not the sole responsibility of ***Whole-Health, LLC*** to know if my insurance will pay for my medical services.

I understand and agree that I am financially responsible for any and all charges my insurance company does not pay for.

I understand that ***Whole-Health, LLC*** is a **Private Family Practice** that offers a variety of medical services including urgent care. In the event my urgent care visit is after-hours, I understand that I am responsible for payment at the time services are rendered.

I understand and agree that ***Whole-Health, LLC*** will submit a claim on my behalf but can not guarantee reimbursement or be held responsible for any policy restrictions or benefit limitations my insurance may apply.

Signature:_____ Date:_____
(please sign here - Patient or Responsible Party)

Responsible
Party Name:_____
(please Print name of Responsible Party if different from patient)

1705 South Federal Highway • Suite A-4 • Delray Beach, FL 33483
Tel: (561) 265-1990 • Fax: (561) 330-9011

FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's rights to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. The following is a summary of your rights and responsibilities as a patient:

RIGHTS:

A patient has the right to be treated with courtesy and respect with appreciation of his/her individual dignity, and with protection of his/her privacy.

A patient has the right to prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his/her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he/she does not speak English.

A patient has the right to know what rules and regulations apply to his/her conduct.

A patient has the right to be given by his/her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rates.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and upon request to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition the will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or health care facility which served him/her and to the appropriate state licensing agency.

RESPONSIBILITIES:

A patient is responsible for providing his/her healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.

A patient is responsible for reporting unexpected changes in his/her health to the healthcare provider.

A patients is responsible for reporting to his/her health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.

A patient is responsible for following the treatment plan recommended by his/her health care provider.

A patient is responsible for his/her actions if he/she refused treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligation of his/her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
☐	☐	☐	☐	☐	☐	☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		