Please print this form, complete it and bring it with you to your next appointment. Do Not E-Mail This Document.

Melinda J Wheatley MD PC

PATIENT DEMOGRAPHIC INFORMATION -

Please Complete This Entire Form. Thank You!

Today's Date:_____/_____/_____ **Referred By *(If Applicable)*: _____**

PATIENT INFORMATION

LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICAL ADDRESS *(If different from mailing address)*:	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**WORK PHONE:** ( )	**EXTENSION:**
E-MAIL ADDRESS: □ None □ Prefer Not to Disclose	**USE E-MAIL ADDRESS FOR PATIENT PORTAL:** □ Yes □ No □ Not Applicable	**Social Security #**	
GENDER: □ Male □ Female □ Transgender □ Unknown	**RACE:** □ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian/Other Pacific Islander □ White □ Refuse to Report □ Other		
ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Refuse to Report	**PREFERRED LANGUAGE:** □ English □ Spanish □ Other Language (*please specify*):		
MARITAL STATUS: □ Single □ Married □ Separated □ Divorced □ Widowed			
DO YOU HAVE A CAREGIVER: □ Yes □ No	**IF YES, NAME OF CAREGIVER:**	**IF YES, MAY WE RELEASE PROTECTED HEALTH INFORMATION TO YOUR CAREGIVER:** □ Yes □ No	

EMERGENCY CONTACT

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TOTHIS INDIVIDUAL:** □ Yes □ No

ADDITIONAL CONTACT #1(OPTIONAL)

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TOTHIS INDIVIDUAL:** □ Yes □ No

EMPLOYER INFORMATION

EMPLOYER NAME:	**EMPLOYER PHONE NUMBER:** ( )
EMPLOYMENT STATUS □ Employed □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
SUBSCRIBER:	**RELATION:**	**SUBSCRIBER:**	**RELATION:**
GENDER: □ Male □ Female □ Transgender □ Unknown		**GENDER:** □ Male □ Female □ Transgender □ Unknown	
DATE OF BIRTH *(mm/dd/yyyy)*:	**SOCIAL SECURITY #:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**	**SOCIAL SECURITY #:**

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from Melinda J Wheatley MD PC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check All That Apply*):

□ Home Phone of Record □ Brief □ Extended
□ Cell Phone of Record □ Brief □ Extended
□ Work Phone of Record □ Brief □ Extended

POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select Only One*):

□ Mailing Address of Record □ Street Address of Record
□ Other:

_____
Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DO NOT RESCUSITATE?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*

PLEASE CONTINUE THE BACK SIDE OF THIS FORM

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at Melinda J Wheatley MD PC which outlines my privacy rights and how Melinda J Wheatley PC may use and disclose Protected Health Information about me.

□ Yes □ No □ Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. **□ Accept □ Decline Initials: _____**

Telephone Contacts, Monitoring and Recording- *I agree that Melinda J Wheatley MD PC Or anyone acting on the behalf of Melinda J Wheatley MD PC) may contact me regarding my Account (including for collections purposes or related to insurance coverage); (2) any and all of Melinda J Wheatley MD PC's contacts with me may be made via text message or with an automated dialing and announcing or similar device; (3) Melinda J Wheatley MD PC may contact me at any telephone number I provide to them, whether a residential or business number, a wireless, cellular or mobile number (including a telephone number converted to a mobile/wireless number, or which connects to any type of mobile/wireless device); (4) I have an established business relationship with Melinda J Wheatley, MD PC and that the office may contact me at the telephone number I provide to them, in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the office of Melinda J Wheatley MD PC.*

□ Accept □ Decline Initials: _____

Health Information Exchange (HIE)

Melinda J Wheatley MD PC may participate in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that Dr Melinda J Wheatley MD may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the office of Dr Melinda J Wheatley MD PC.

All patients may be automatically enrolled in the HIE unless the Opt Out box is checked and initialed. **□ Opt Out Initials: _____**

Confidential Communications

I understand Dr Melinda J Wheatley MD PC will notify me if it is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency

I understand that my protected health information may be released as my physician determines appropriate in an emergency.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to Melinda J Wheatley MD PC (DBA the Physicians Center for WellBeing) or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to Melinda J Wheatley MD PC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Melinda J Wheatley MD PC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand the above statements.

Patient Printed Name	Patient Signature	Date Signed

Legal Guardian Printed Name (*if applicable*)*	Legal Guardian Signature (*if applicable*)*	Date Signed

***PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.**

Melinda J Wheatley MD PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW IT CAREFULLY***.

Melinda J Wheatley MD PC is required by law to maintain the privacy of patients 'personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. Melinda J Wheatley MD PC is required to abide by the terms of the Notice of Privacy Practices as necessary and make the new Notice effective for all personal health information maintained by our office. You may receive a copy of any revised notices by mailing a request to Privacy Officer, Melinda J Wheatley MD PC 1140 South Linden Road Flint, MI 48532.

USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, our office will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the disclosure. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Uses and Disclosures for Treatment. Melinda J Wheatley MD PC will make uses and disclosures for your personal health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. Our office may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. For instance, if you are going to receive home care or are being referred to a specialist for treatment, our office may release your personal health information to that facility so that a plan of treatment can be prepared for you.

Uses and Disclosure for Payment. Melinda J Wheatley MD PC will make uses and disclosures of your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, our office may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you, or we may use your information to prepare a bill to send to you or the person responsible for your payment.

Family and Friends Involved in your Care. Melinda J Wheatley MD PC may, from time to time, disclose your personal health information to family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and it is determined that a limited disclosure may be in your best interest, limited personal health information may be shared with such individuals without your approval.

Appointments and Services. Melinda J Wheatley MD PC may contact you to provide appointment reminders or test results. You have the right to request, and our office will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, you may wish appointment reminders not to be left on voice mail or sent to a particular address. You may request such confidential communication in writing. Request forms may be obtained from registration at our office.

Health Products and Services. Melinda J Wheatley MD PC may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services offered by our office and to provide general health and wellness information.

Other Uses and Disclosures. Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under State law to appropriate State or local authorities. Dr Melinda J Wheatley MD PC is permitted or required by law to make certain other uses and disclosure of your personal health information without your consent or authorization:

- •For any purpose required by law; for public health activities, such as required reporting of disease, injury, birth, death, and for required public health investigations.
- •For suspected child/elder abuse or neglect; or if there is suspicion that you may be a victim of abuse, neglect or domestic violence.
- •To the FDA to report adverse events, product defects, or to participate in product recalls.
- •To your employer when LCFP has provided health care to you at the request of your employer to determine workplace-related illness or injury.
- •To coroners and/or funeral directors consistent with the law.
- •If necessary to arrange an organ or tissue donation from you or a transplant for you.
- •If you are a member of the military as required by armed forces services; or if necessary for national security or intelligence activities.

Melinda J Wheatley MD PC may release your personal health information in accordance with any state laws that are more restrictive or limiting than federal privacy regulations.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to inspect and/or copy much of the personal health information that our office retains on your behalf.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information maintained by Melinda J Wheatley MD PC be amended or corrected. Our office is not obligated to make all requested amendments but will give each request careful consideration.

Accounting for Disclosures of your Personal Health Information. You have the right to receive an accounting of certain disclosures made by Melinda J Wheatley MD PC of your personal health information after April 14, 2003. The first accounting is free; you will then be charged a fee of $5.00 for each subsequent accounting.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain uses and disclosures of personal health information for treatment, payment, or health care operations. Our office is not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate.

All requests for Access, Amendments, Accounting for Disclosures, and Restrictions on Use and Disclosure must be in writing and signed by you or your representative. Forms can be obtained from our receptionist.

RECORDS

Charts that have been inactive for 10 years are destroyed except for the charts of children which are kept until the child is 18 years old.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with the Melinda J Wheatley MD PC Privacy Officer by mail or by telephone. Please direct correspondence to: Judy Myers 1140 Linden Road, Flint MI 48532.
You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights.

Patient Financial Policy

Thank you for choosing the Physicians Center for WellBeing as your health care provider. We are committed to building a successful physician-patient relationship for you and your family. It is the goal of The Physicians Center for WellBeing to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to have a clear understanding of your patients' financial responsibility. Please understand that payment for services is part of that relationship. Please read the following information carefully and feel free to ask any questions you may have in any area. We ask that you sign this statement when you have read and understand each point covered.

Registration:

Upon registration, each patient is asked to complete our Patient Information Form, a Medical Information sheet, and a Financial Responsibility Waiver. We ask for a copy of your driver's license and copy of your insurance card. We also ask for your permission to take a photograph for your medical chart. Scanned copies of your insurance card and driver's license are part of your medical record. It is your responsibility to notify our office of any patient information changes such as address, name, telephone number and insurance information.

Guarantor

Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Co-Payment

A patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment- unless previous arrangements have been made. We accept, cash, checks or credit cards. We also have a policy which enables our office to maintain your credit card information as well as your Health Saving or Flex Spending Card on file and process deductibles and outstanding balances that your insurance has processed and deemed your responsibility. Please see the Credit Card on File Agreement for further information.

Returned Checks

There is $ 35.00 fee for all checks presented for payment with non-sufficient funds (bad checks). No postdated checks will be accepted.

Insurance Claims

We verify coverage on the day of your appointment. If we cannot verify active coverage, your appointment must be rescheduled. It is your responsibility to know what your insurance benefits cover and if we are an in-network or out of network provider. Some plans also have tiered coverage.

If you have health insurance, this is an agreement between you and your insurance carrier to pay for medical care. In most cases, we are not a party of this contract. We will bill your insurance company as a courtesy. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill.

If your insurance is not contracted with us, you agree to pay any portion of the charge not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forwards the payment to us immediately. Our office policy requires payment from your carrier within 45 days. If we do not receive payment from your insurance carrier, the balance will be transferred to your responsibility. The only exception to the above policy applies to those patients who are covered by insurance companies that we are contracted with.

Patient Statement/Past due accounts

You will receive a patient statement from our office informing you of the balance that is due after your insurance has processed their portion. Payment is required within 30 days.

There is an additional service fee of $ 2.00 for each monthly statement mailed after the initial statement. If we do not receive any payments after 90 days from the date of service, or insurance processing date, we reserve the right to refer your account to an outside collection agency where you will be responsible for all collection and legal fees. We also reserve the right to terminate the patient and physician's relationship due to non-compliance with office policy.

Missed Appointments

If you need to cancel an appointment, we ask for at least a 24-hour notice. This allows us to offer the appointment to another patient. If you fail to keep appointments without letting us know in advance there may be a $ 50.00 charge.
We reserve the right to terminate the patient and physician's relationship due to frequent no shows and cancellations.

Prescription Refills

A $ 25.00 fee may apply for any after hour phone services rendered or prescription phone services.

Clerical Paper Work

Additional fees apply for clerical work such as sick leave, disability papers, etc.

AUTHORIZATION TO RELEASE INFORMATION: I understand that The Physicians Center for WellBeing will maintain records of my contacts for services and in general no information will be released without my specific written consent. I am aware, however, that information concerning my treatment and services rendered may be released as necessary to receive reimbursement by public and private health insurance plans. I authorize The Physicians Center for WellBeing to release any medical/psychiatric/substance dependency information necessary for the processing of claims. I permit a copy of this authorization to be used in place of the original. I request that payment under my medical insurance be made directly to The Physicians Center for WellBeing. I understand I am responsible for charges not paid by my insurance carrier.

I HAVE READ THE FINANCIAL POLICY (ABOVE). I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____ Date:

Signature

The Physicians Center For Wellbeing

Newborn/Pediatric History (nb-11 years old)

Name: _____ Date: _____
DOB: _____ Gender: _____ Race: _____ E-mail: _____
Parent/Guardian: _____ Home phone: _____
Address: _____ Work phone: _____
Insurance Company: _____ Contract #_____ Group #_____

Allergies

Is child allergic to:	Yes	No	Explain
Penicillin			
Sulfa			
Codeine			
Other antibiotics			
Other drugs			
Any foods			

Immunizations/Tests

Immunization	Date	Date	Date	Date	Date
DPT/TD					
Polio					
HIB					
HEP B					
MMR					
Varicella					
TB Tine test					

Current Medications

Include prescription, over-the-counter, inhalers, vitamins, herbs, special diets

Medication	Dose/Strength	How often	Medication	Dose/Strength	How often

Maternal/Newborn History

Did mother	Yes	No		Yes	No	
Have any health problems during pregnancy			Breastfeeding			
Use tobacco, alcohol or recreational drugs during pregnancy			Formula			What brand
Deliver via vaginal			Birth weight			
Deliver via C-section			Discharge weight			
Was birth on time			APGAR score			
Have any problems with pregnancy, delivery or newborn			Explain			

Pediatric Health History

Has the child had	Yes	No	Has the child had	Yes	No	Has the child had	Yes	No
Asthma			Allergies			Skin problems		
Tonsillitis			Sleep apnea			Seizures		
Chicken pox			Heart murmur			Kidney problems		
Pneumonia			Constipation			Bed wetting		
Blood disorders			Frequent headaches			Frequent ear infections		
Hearing loss			Urinary tract infections			Frequent sore throats		

The Physicians Center For Wellbeing
Newborn/Pediatric History

Name: Date:

Hospitalizations/Surgeries/Procedures

Reason	Year	Doctor	Hospital

List Consultants/Doctors

Are you under the care of any other doctors at this time Yes☐ No ☐

Doctor	Reason

Family History

	Mother	Mother's Mother	Mother's Father	Father	Father's Mother	Father's Father	Sibling	Sibling	Sibling	Sibling
Age (if living)										
Health (G)ood (B)ad										
Cancer										
Tuberculosis										
Diabetes										
Heart Problems										
High Blood pressure										
Stroke										
Epilepsy										
Asthma										
Blood disease										
Depression										
High cholesterol										
AIDS										
Osteoporosis										
Age (at death)										
Cause of death										

Safety Education/Abuse

	Yes	No		Yes	No
Does anyone smoke at home			Do you always use a carseat		
Do you have a smoke detector			Are seatbelts used		
Are guns stored in a locked cabinet			Is the hot water temperature 120 or lower		
Is the ammunition stored separately			Is there any family abuse		
Does your child wear a helmet when riding a bike, skating, etc.			Is the poison control phone number posted		

I certify that the above information is correct to the best of my knowledge. I will not hold my practitioner or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature Date