PREMIUM WELLNESS
& PRIMARY CARE

PATIENT REGISTRATION

Patient: ______________________ **DOB:** ___ /___/____ Age: ______ **Sex:** ___ **F** / ___**M**

Address: ______________________ **Contact #:** ______________________(Home)

______________________ ______________________(Cell)

Race: American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
White
Patient Declined / Other: ______________

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Patient Declined
Marital Status: Single / Married / Other______________

Language Preferred: ______________________

E-Mail: ______________________ **SS#** :______________________

Insurance Information (A photo copy of your Current Insurance Card is Required at the Time of Service)

Primary Insurance: ______________________ Secondary Insurance: ______________________

Primary Insured Name: ______________________ DOB: ___/___/___ Relationship: ______________________
(If Not Self)

Self-Pay / File Primary / Secondary Insurance / Bill Corp Acct / Worker's Comp OR Other ______________________

Employer: ______________________ Occupation: ______________________

Address: ______________________ Contact Name: ______________________

______________________ Contact Number: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Address: ______________________ Contact Number: ______________________

____

Family Physician: ______________________ Pregnant? Y / N Pacemaker? Y / N

Patient Agreement: Assignment and Release

I, the undersigned, have insurance coverage with ______________________, and assign directly to Premium Wellness & Primary Care all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or NOT paid by my insurance. I hereby authorize the use if this signature on all my insurance submissions. I further authorize Premium Wellness & Primary Care to forward any information necessary to the insurance company for payment of my insurance claims.

Signature of Insured / Guardian ______________________ Date: ______________________

Excellence. Every Patient. Every Time.

4002 Spring Garden St. Ste. C
Greensboro, NC 27407

Family Medical Care

www.premiumwellnesspc.com

Effective Date of this Notice: October 03, 2016

Premium Wellness & Primary Care, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____, understand Premium Wellness & Primary Care's Notice of Privacy Practices, and would like to receive/decline a hard copy. (circle one)

____ ____________________

Patient/Guardian/Parent Signature **Date**

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ePrescribing

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy of choice in a safe secure way. Which helps to protect the privacy of your personal information.

ePrescribing also allows your provider to see important information- like drug interactions and your prescription history.

Benefits as the patient include:

- ✓ Less confusion over handwritten prescriptions or unclear phone calls
- ✓ Possibilities for medical errors as well as adverse drug reactions are reduced
- ✓ Prescriptions are transmitted to the pharmacy, limiting the responsibility of the patient keeping up with paperwork
- ✓ A safe, fast, easy way to get your prescription filled

Patient Consent to ePrescribing

I agree that Premium Wellness & Primary Care may request and use my prescription medication history from other health-care providers or third party pharmacy benefit payers for treatment purposes.

I Accept / I Decline

______________________________ ______________________

Patient / Guardian Signature **Date**

Patient History

Today's Date ____/____/____

Patient Name: ______________________________ Date of Birth: ____/____/____

Family History	Family Member (List)	Personal Past Medical History	Number of Years
Cancer		Cancer	
Cancer of breast		Diabetes	
Cancer of prostate		Heart disease	
Diabetes		Hypertension	
Heart problems		Kidney problems	
Hypertension			
Kidney disease			
Respiratory disease			

Social History:

Alcohol Use: Yes / No Drink(s) per week ______________

Do you exercise routinely?: Yes / No _________ x(s) per week

Illegal or Street Drug Use: Y / N If yes please specify:___________________________

Caffeine Use: Y/ N If yes please specify:______________________________________

Tobacco Use: Yes / No Number per day___________________ for ________ year(s)

Quit (year) _____ Smoked ______ pack(s) per day for _ year(s)

Personal History:

Sexually Active: Y / N Hepatitis C: Y / N

My last physical was approximately _________ year(s) / month(s) ago

Date of last Menstrual Cycle: _____________________________ Normal / Abnormal

Date of last Pap Smear: ________________________________ Normal / Abnormal

Date of last Flu Immunization ____

Date of last Pneumonia Immunization _______________________________________

Have you have any type of Surgeries? _______________________________________

What was the date of your last:

Colonoscopy ____________________________________

Mammogram ____________ _______________________

Cholesterol Check ________________________________

PSA ____

Hepatitis C Screening: ______________________________

Pharmacy of Choice : ____

. (Name & Location)

Drug Allergies:____

Over the past (2) weeks how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?
2. Feeling down depressed or hopeless?

Not at all	Several Days	More than one half of the days	Nearly everyday
0	1	2	3
0	1	2	3

Date of Visit (if still taking medication mark with a √)

Medications	Strength	Dose	X Per Day				

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Insurance Policy

- Premium Wellness & Primary Care will file your claim to your primary insurance, if your have more than one insurance carrier, as a courtesy we will attempt to file a secondary claim, you must provide accurate information at the time of service.
- A copy of your insurance card(s) is required in order for us to file your claim. Otherwise, you will be expected to pay in full for the services rendered.
- If we are unable to verify your insurance coverage, you maybe required to reschedule you appointment until we can contact someone.
- You may be allowed to be seen but you will be required to pay for your visit in full, once we are able to file your claim and payment is received form your insurance company, we will reimburse any money that is owe.
- Copayments, Coinsurance, and Deductibles are collected in advance, Unless prior arrangement's have been made.
- We accept the following forms of payments: cash, checks, credit or debit cards with the logo: Visa, Master Card, American Express or Discover.
- There will be a $25 service charge as well as the bank fee on all returned payments.
- Premium Wellness & Primary Care will try to accept assignment on the following insurance companies: Medicare Part B, Medicaid, Blue Cross and Blue Shield, United HealthCare, Humana, Cigna, MedCost and Aetna.
- Any HMO policies are subject to the patient policy requirements which may or may not be able to be filed without authorization.
- It is your responsibility to know your coverage. You will be held responsible for all unpaid charges which may be subject to a 25% collection fee.

______________________________ ______________________

Patient/ Guardian Signature **Date**

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4002 Spring Garden St. STE. C * Greensboro, NC 27407
* Phone 336.553.0793 * Fax 336.553.0795
www.premiumwellnesspc.com

Patient Authorization for Use and Disclosure of Protected Health Information

In general, the **Health Insurance Portability and Accountability Act (HIPAA)** privacy rule gives individuals the right to request a restriction on uses and disclosures of the protected health information and in keeping within the **HIPAA** guidelines, we ask patients to give us the name of the individuals that Premium Wellness & Primary Care may speak with regarding your medical care. The purpose of disclosure is so **Premium Wellness & Primary Care** may make an informed decision as to whether to release your information. I further understand that this authorization is voluntary and that I may refuse to sign this authorization and it will in no way affect eligibility, benefits, or enrollment for or coverage of services.

Please List the person(s) in which you wish to authorize our facility to speak with, and the information you would like to either allow or keep restricted.

Name: ____

Relationship: ________________ Allowed: __________ Restricted: __________

Information: ____________________ Purpose of Disclosure: ________________

Name: ____

Relationship: ________________ Allowed: __________ Restricted: __________

Information: ____________________ Purpose of Disclosure: ________________

I understand that my information will only be shared with my permission. I also understand that this release of information expires (Date: ____________), or with receipt of a new signed document.

Patient / Guardian Signature______________________________ Date: __________

Printed Name (& Relation if not Patient) ______________________________

Witness Signature: ______________________ Print Name: ________________

Office use Only

Patient Name: ____________________________________ DOB: ___/___/___

Staff Member: ____________________________________ Date: __________