Weaver Health Services, LLC.

Ringgold Ready Clinic / Flintstone Ready Clinic

Walk In & Family Medicine

Patient Information

Please print

____

Legal First Name | Legal Last Name | Preferred First Name

____

Male/Female | Date of Birth | Social Security #

Mobile Phone ______________ Home Phone ______________ Work Phone ______________

Email ________________________ Would you like email appointment reminders? Yes No

Preferred Method of Communication E-mail Home Cell Work

Address ____

Preferred Pharmacy ____

Can we retrieve your prescription history from your pharmacy? Yes No

Responsible Party's Information/Guarantor: ________________________
Inital here if same as above

Name ________________________ Relationship to Patient ________________________

Social Security # ________________________ Date of Birth ________________________

Address ________________________ Phone # ________________________

Ethnicity (Circle) Hispanic Latino Non-Hispanic

Race (Circle) American Indian Asian Black/African American
Native Hawaiian or Other Pacific Islander White Other

Name of Emergency Contact/Next of Kin ________________________

Relationship to Patient ________________________ Phone # ________________________

Address ____

____

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Insurance Information

Please present your insurance card and ID with this form if you have not already done so.

Primary Insurance Plan Name ______________________________

Secondary Insurance Plan Name (If applicable) ______________________________

If policy holder name is different than patient, please fill out below.

Subscriber Name ______________________ Relationship to patient ______________________

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, finding and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writting.

In the event we are unable to reach you by phone, may we leave a detailed message on your voice mail? Yes No

Weaver Health Services

DBA/ Ringgold Ready Clinic - Flintstone Ready Clinic

CONSENT FOR TREATMENT - ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name: ____ DOB: _____/_____/_____

1. CONSENT TO TREAT: I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Weaver Health Services and its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been made to me as a result of the treatment of care.

2. ASSIGNMENT AND RELEASE: I have medical insurance and assign directly to Weaver Health Services physicians all medical benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. In the event of default of payment, I agree to pay all costs of collections including attorney fees. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. FINANCIAL AGREEMENT: I will make every effort to actively assist Weaver Health Services with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Weaver Health Services submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Weaver Health Services to process insurance claims, I will be responsible to pay Weaver Health Services full and standard fees.

4. STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN): I request that payment of authorized Medicare benefits be made on my behalf to Weaver Health Services for services furnished to me by a Weaver Health Systems clinic, including physician services. I authorized any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and Its agents any information needed to determine these benefits or benefits for related services.

CONTROLLED MEDICATION POLICY ACKNOWLEDGEMENT

I understand that Ringgold Ready Clinic is primarily staffed with nurse practitioners. In the state of Georgia, a nurse practitioner cannot order/prescribe Schedule II narcotics, therefore, these will not be written unless the MD sees me and prescribes them to me. These medications include, but are not limited to Adderall, Hydrocodone, Oxycodone, Ms Contin, and Percocet. I further understand that no other controlled substance will be called in after normal operating hours of the clinic. I also agree to comply with all state and federal regulations regarding random drug testing as well as being seen intermittently by the MD for any scheduled medications that are written by the NP. If requirements are not met, I understand that refills will not be given.

______________________________	______________________________	____/____/____
Printed Name of Patient/Authorized Representative	Signature of Patient/Authorized Representative	Date

RECEIPT OF HIPAA PRIVACY NOTICE: I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices." I understand the Notice of Privacy may change over time and that the obligations of Weaver Health Services and my rights under it may change. **Initial: ________.**

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MEDICAL HISTORY for CHILDREN (under 18 yrs)

Patient's Name: ____________________

Patient's Date of Birth: ____________ Today's Date: ____________

Reason for today's visit ____________________

PAST MEDICAL PROBLEMS - Please indicate if YOU have a history of the following:

Please CIRCLE all that apply

I HAVE NO SIGNIFICANT MEDICAL PROBLEMS

Abdominal Problems	Constipation	Joint/Bone Problems	School Problems
Any Serious Injury	Frequent Temper Tantrums	Kidney/Bladder Infections	Seizures
Asthma	Sinus Problems	Multiple Ear Infections	Underweight
Behavior Problems	Allergy Problems	Over Weight	Vision Problems
Broken Bones	Heart Problems	Pneumonia	Other ____________
Chronic Cough	Birth Defects		

Any allergies to medications? ____________________

Any allergies to food or environment? ____________________

List any meds your child is taking: ____________________

SOCIAL HISTORY

Child has how many sisters? ____________ Brothers? ____________

Grade in School ____________

Usual grade received ____________ (A, B, C, etc)

Is your child in daycare / After school care? ____________

Who lives in your home? ____________________

FAMILY HISTORY Has any blood relative of child had:

Alcoholism	Deafness	Heart Vessel Surgery	Seizures
Allergies	Depression	High Blood Pressure	Stroke
Bleeding Disorder	Diabetes	High Cholesterol	Tuberculosis
Blood Clots	Drug Addiction	Lung Disease	Other ____________
Cancer	Heart Problems	Mental Illness	