WESTERN MEDICAL ASSOCIATES, PC

PATIENT INTRODUCTION PACKET

☼ **Patient Agreement** – READ CAREFULLY – VERY IMPORTANT

- Please read, sign and date at the bottom of the agreement and return to Western Medical Associates with the new patient paperwork.

☼ **Additional Patient Information / Medication Refill Policy**

- Please read both sides and keep for your information.

☼ **CMS 1500 (Insurance Claim Form)**

- Please read back of form and then sign and date boxes 12. and 13. on the front of the form. Fill in ONLY the darkly outlined boxes at the X's.

☼ **New Patient Paperwork**

- *Patient Information Sheet* – Fill out completely with patient's information, sign and date. Patient will be asked to present insurance information at the first visit, so "see card" may be written in the insurance information blocks. Must have insurance cardholder's name, date of birth, social security number as well as address and phone number (if different from the patient).

- *HIPAA Notice of Privacy Practices* – Read, sign and date on back side of form.

- *Confidential Communication of Protected Health Information* – This form is designed to give Western Medical Associates permission to speak to someone besides the patient regarding his/her medical condition, prescriptions, test results and/or payment information. Please fill out, sign and date.

- If patient is coming from another physician or medical group, please fill out the *Medical Records Request* so that we can get the necessary records from that facility for the selected WMA provider.

WESTERN MEDICAL ASSOCIATES, P.C.

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY

Name _____ Sex Male ☐ Female ☐
Last First Middle

Mailing Address _____
City State Zip

Physical Address _____
City State Zip

Home Phone ( ) Cellular ( )

Date of Birth / / S.S.N. - -

Marital Status (circle) Single Married Divorced Widowed Separated If Married - Spouse's Name _____

Employer _____ Work Phone

Employer Address

In Case of Emergency _____ Relationship _____ Phone

INSURANCE INFORMATION (PRIMARY - if applicable)

Insurance Company Name _____ Policy Number

Address _____ Group Number
City State

Name of Insured (policy holder)

Social Security Number - - Date of Birth / /

RESPONSIBLE PARTY (if different from patient)

Name _____ Relation to Patient

Address _____ Telephone
Street / PO Box City State

Social Security Number - - Date of Birth / /

Employer _____ Work Telephone

Employer Address

INSURANCE INFORMATION (SECONDARY - if applicable)

Insurance Company Name _____ Policy Number

Address _____ City State Group Number

Name of Insured (policy holder)

Social Security Number - - Date of Birth / /

WESTERN MEDICAL ASSOCIATES, P.C.

6500 East Second St. Ste 200
Casper, WY 82609

Phone (307) 577-5100
Fax (307) 234-1201

Dear Patient;

Thank you for choosing Western Medical Associates for your health care needs. Our providers and staff are dedicated to providing you the best care and customer service possible. In order to avoid common misunderstanding, please take a few moments to read and sign the following **Patient Agreement**:

_____ (herein called the "patient") has entered into an AGREEMENT with Western Medical Associates (herein called "WMA").

- **New patient only –If a new patient does not show up for their first scheduled appointment and gives no notice, WMA may choose not to accept the patient into the practice.**
- I promise to call WMA at least 24 hours prior to my appointment if I need to cancel, so that another patient may be treated in my time slot.
- I promise to conduct myself in an orderly manner while at WMA or on the phone (no swearing, angry outbursts, rudeness to WMA staff, etc) or I may be terminated from the practice.
- It is my responsibility to be on time for my appointment. I understand that being more than 15 minutes late for an appointment may result in my appointment needing to be rescheduled. When you do not show up for your scheduled appointment, it hurts other patients who need to see our providers.
- I understand that I am a participant in my own health care, and that I am responsible for following my provider's healthcare plan for my own benefit.
- I understand that if I am a WMA patient who receives ongoing treatment/medication management, I need to have an appointment with my primary provider at least one time per year to renew medications as well as review and assess treatment. Failure to follow up as recommended could result in termination from the practice.
- I understand that I, the patient/guarantor, am responsible for full payment of any and all services rendered by WMA to me or my family members, including all services not covered by insurance. **WMA bills my private insurance as a courtesy and I, as the subscriber, am responsible for understanding the terms of my policy.** Any unpaid balance that has been billed to private insurance, after forty-five (45) days, is patient/guarantor responsibility. In the event of non-payment, I agree to pay all reasonable attorney fees and court costs if WMA refers my account to a third party collection agency
- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
- I understand that as long as I participate and uphold my end of this Agreement, I am always welcome at WMA.

IN AGREEMENT THIS _____ DAY OF _____, 20_____.

_____
Patient Name (Print)

_____
Authorized WMA Official

_____
Patient or **Guardian Signature** *(if patient is under 18)*

ANY CHANGES OR ADDITIONS TO THIS AGREEMENT ARE NOT PERMITTED

5/2018

WESTERN MEDICAL ASSOCIATES, P.C.

CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Verbal information about my general medical condition, diagnosis as well as treatment, and payment information may be released to: (Please list name and phone number)

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

The following person(s) have my permission to make phone calls about my appointments or pick up my samples and/or prescriptions: (Please list name(s) – these persons will be asked to present ID)

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

_____ Relationship: _____ Phone #: _____

ONLY IN AN EMERGENCY, please notify: (Please list name and phone number)

_____

_____

_____ _____

Signature of Patient or Parent/Guardian **Date**

* This CCPHI is not valid for printed records, **only** verbal communication.

5/2018

PERMISSION TO TREAT MINOR CHILD

Date _____

I, _____, parent/guardian of

_____, minor child, give my
(PATIENT NAME)

permission for _____ to accompany

my child for examination and/or treatment at Western Medical Associates

this _____ day of _____, 20_____.

CHECK ONE

_____ This is permission for stated appointment date only

_____ This is permission for any appointments in the future

_____

Parent/Guardian Signature

Western Medical Associates, PC.
6500 E 2nd St. Ste. 200 Casper, WY 82609
(307)577-5100 *phone* (307)234-1201 *fax*

Authorization for Disclosure of Protected Health Information

Patient Name:_____
Telephone #:_____
Date of Birth:_____
SSN#:_____

RELEASE FROM

_____

_____

_____

_____

*give complete information of where records are being requested from, including physician name, phone and fax number, and address if applicable. Failure to provide this information could result in a delay of processing.

RELEASE TO

WESTERN MEDICAL ASSOC.
6500 E 2nd St. Ste. 200
Casper, WY 82609

(307)577-5100 *phone*
(307)234-1201 *fax*

Purpose of disclosure:_____

Information to be disclosed:
Entire record_____
Lab reports_____
Radiology reports_____
Other (specify)_____

Dates(if applicable):
_____
_____
_____
_____

Specific authorization to disclose sensitive records
I authorize the disclosure of these additionally protected records (please initial next to each):
Alcohol and/or substance abuse records_____
Mental Health records (depression/anxiety)_____
Other Mental Health/Psychiatric records_____
Sexually transmitted disease information_____
HIV/AIDS information_____
*Federal law prohibits the re-disclosure of this information without the express written permission of the person to whom it pertains.

_____ _____
(Signature) (Name Printed)

_____ _____
(relation to patient/authority to act for patient) (Date)

*HIPAA allows 30 (thirty) days for a provider to respond to your request for records. Western Medical Associates medical records policy calls for a standard 2 (two) week turn around on all records requests. In certain instances, there may be applicable fees for copying records, including postage. This medical release form is valid for above stated medical records for 1 (one) year from signed date. Records will not be faxed to an unsecure fax line. I understand that I may revoke this authorization in writing at any time prior to Western Medical Associates, PC, acting upon the authorization. I understand that Western Medical Associates, PC, may not base treatment or payment upon completion of this form. I understand that disclosed information may be subject to re-disclosure by the recipient and may no longer be protected by federal law, if the recipient is not a "covered entity."