# Henderson Wellness Center
# Medical Patient Update Form

Please help us keep accurate records by filling out this form completely. This will assist us in making referrals and sending prescriptions

Name Mr. Mrs. Miss Ms. (circle one) _____

Date of Birth_____ Address _____

City _____ State ____ Zip _____

Home Phone _____Cell Phone _____ (text reminders Y/N)

Cell Phone Carrier: _____

Married ___ Single ___ Divorced ___ Widowed ___

Email address _____

Occupation _____ Employer _____

Phone _____

Emergency Contact Name _____ Number _____

Have there been any changes to your insurance since your last visit? Yes No
If so, what changes have been made? _____

**HIPPA Release:**

I authorize you to release the following information to the people listed below. This release is valid until I revoke it in writing.

a. Relationship

b. Relationship

c. Relationship

d. Relationship

A full disclosure of your HIPPA rights are available upon patient request.

Signature: _____ Date: _____

Print name of Patient: _____

POLICY STATEMENT: PAYMENT POLICY ____Initial

- You will be required to provide proof of insurance at every visit. In compliance with new federal law, we will ask you for photo identification.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you; however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and complies with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Henderson Wellness Center, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf if your insurance card is **presented at the time of service.**
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to pay in full at the time of your office visit.
- If your deductible hasn't been met for the year, we require you pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed. All co-payments are also due at time of service.
- We accept cash, check, and credit or debit card payments. There is a $40.00 return check fee in addition to fees charged by your financial institution.
- If your insurance carrier has not paid a claim submitted by Henderson Wellness Center within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid a claim submitted by Henderson Wellness Center within ninety (90) days of submission, you will be **responsible for payment in full** of any outstanding balance. If your personal balance exceeds $100 at any given time, your care may be terminated. If a collection agency is used to collect any past due balances, you will be responsible for expenses incurred in collecting that debt including but not limited to attorney fees and court cost.

**Policy Statement: Cancellation/ No Show _____Initial**

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 missed appointment fee; this will not be covered by your insurance company.**
- We understand that delays can happen however we must try to keep other patients and doctors on time. If a patient is 15 minutes past their scheduled appointment time we will have to reschedule the appointment.

**Signature:** _____ **Date:** _____

**If Parent or Guardian, Name of Child:** _____