Ortega Wellness

New Patient Registration

First Name:_____Last_____

DOB:_____ *Social Security #:_____

Address:_____City:_____State:_____Zip:_____

Primary Phone:_____ Work Phone:_____

Email:_____ Occupation: _____

Marital Status ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Emergency Contact

Name:_____ Relationship:_____

Phone Number:_____

Insurance Information

Primary Insurance: _____ Member ID#_____ Group #_____

Secondary Insurance:_____ Member ID#_____ Group #_____

Are you the primary insured? Yes ___ No ___ ***If no, please provide the following information:***

Primary insured's name: _____

Date of birth: _____ SS#: _____

Relation to patient: _____

Employer: _____

How did you hear about us? _____

Consent for Medical Treatment

I hereby consent to the procedures which may be performed during this examination, including services which may include but are not limited to laboratory procedure, diagnostic procedures, surgical treatment or procedures, or other urgent services rendered to me under the general and special instructions of the medical provider.

Patient Signature: _____ **Date:** _____

Notice of Privacy Practices

I hereby acknowledge that I have been notified of the privacy practices which describe the way in which the facility may use and disclose my healthcare information for treatment, planning my care, payment of services, healthcare operations, a tool for assessing quality, and other described and permitted uses and disclosures. The staff at the facility is given permission to contact me in regards to my appointments, lab results, follow ups, and referrals. I understand I am able to request my labs, referrals, and procedures if needed.

Patient Signature: _____ **Date:** _____

Payment Agreement

- Payment is due at the time of service regardless if the health plan has a copay or deductible. We will file with all contracted health insurance companies and Medicare, but the patient is ultimately responsible for payment. We accept cash, bank debit cards and credit cards
- Please disclose changes or additional insurance coverage as soon as possible.
- As a patient and/or responsible party, you will be responsible for any balances due to Ortega Wellness that are not paid by your insurance.
- Be advised, if balances go unpaid for >90 days, balances will be sent to collections agencies. Guarantor (the person responsible for paying the bill) will be responsible to pay all costs of collections, including reasonable interest and reasonable collection agency fees

Patient Signature: _____ **Date:** _____

Patient Responsibilities

- Please arrive 10-15 minutes prior to your appointment to be signed in, and fill out any necessary paperwork.
- If you are more than 10 minutes late to your appointment you will be asked to reschedule.
- Please allow us a 24-hour notice to cancel your appointment, to avoid a **$75.00** fee upon your next visit and will not be seen until it's paid.
- If you have 2 consecutive or more No Call/No Shows or 4 No Call/No Show per year you may be discharged from any further care.
- We understand that unforeseen circumstances may arise, however we cannot guarantee that we can accommodate those changes.
- You will be required to bring your insurance card, ID and a list of your current medications, or the prescription bottles to **ALL** your appointments or you will be asked to reschedule.
- Please make sure that we have all updated information including phone numbers, addresses, and insurance information. If we do not have the correct information you may be responsible for any uncollected balances.
- We will make all attempts possible to reach you regarding referrals, and lab results. If we are unable to reach you it is your responsibility to reschedule a follow up. .
- Appointments must be scheduled for any refills on controlled substances, **NO EXCEPTIONS**.
- Please contact your pharmacy for any refills of a non-controlled medication as they will contact the provider directly with a faster response time.
- Any messages left for the provider may take up to 1-2 business days to be returned. All questions or concerns will be addressed by staff. Our providers do not take phone calls.
- Any letter requests or paperwork for the provider to fill out may take up to 7 business days to be completed.

Print:_____Sign:_____Date:_____

(OPTIONAL)

Patient Authorization for General Disclosure and or Request for Restricted Protected Health Information

I hereby request the following use or disclosure of my health information as described

Patient Name_____ DOB_____

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/provider about my case regarding appointments, blood work etc. I have the right to terminate this agreement at any time by informing a representative of Ortega Wellness.

Authorized Name	Relationship to Patient
_____	_____
_____	_____

DO NOT discuss or provide information to the following individuals or entities:

Restricted Name/ Entity	Relationship to Patient
_____	_____
_____	_____

Signature of Patient_____ Date_____