Mental Wellness M.D.

New Patient Registration Form

Patient Information: **Date: _____**

Last Name:	First Name:	Middle:
Preferred Name:		
Date of Birth:	Social Security Number: __ __ __ - __ __ - __ __ __ __	Sex: M___ F___
Driver's License Number:	Marital Status (circle one): Single Married Separated Divorced Widowed	
Street Address:	City, State, Zip:	

Cell Phone: (_ _ _) _ _ _ - _ _ _ _ Ok to leave message: Y N	Home Phone: (_ _ _) _ _ _ - _ _ _ _	Email Address: Ok to contact you here: Y N

Emergency Contact

Name:	Phone: (_ _ _) _ _ _ - _ _ _ _	Relation:

Employment

Employment Status (circle one): Full-time Part-time Retired Unemployed
Occupation/Position: _____
Employer: _____
Employer Address: _____
Employer Phone: (_ _ _) _ _ _ - _ _ _ _

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Primary Care Physician:	
Name: Address/Town:	Phone: (_ _ _) _ _ _ - _ _ _ _
Preferred Pharmacy Name: Town:	

What is your major complaint?

Current Symptoms:

☐ Anxiety	Mild	Moderate	Severe
☐ Depression	Mild	Moderate	Severe
☐ Hallucinations	Mild	Moderate	Severe
☐ Loss of Interest	Mild	Moderate	Severe
☐ Sleep Changes	Mild	Moderate	Severe
☐ Appetite Change	Mild	Moderate	Severe
☐ Excessive Energy	Mild	Moderate	Severe
☐ Impulsivity	Mild	Moderate	Severe
☐ Panic Attacks	Mild	Moderate	Severe
☐ Avoidance	Mild	Moderate	Severe
☐ Suspiciousness	Mild	Moderate	Severe
☐ Employment	Mild	Moderate	Severe
☐ Fatigue	Mild	Moderate	Severe
☐ Irritability	Mild	Moderate	Severe
☐ Racing Thoughts	Mild	Moderate	Severe
☐ Libido Change	Mild	Moderate	Severe
☐ Forgetfulness	Mild	Moderate	Severe

Anything else you would like the Doctor to know?

_____

_____

_____

_____

45 South Main Street, Suite 302, West Hartford, CT 06107 • 860.698.3600 • Fax: 860-698-3601

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Patient Confidentiality and Protected Health Information

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

Privacy Contact: If you have any questions about the policy or your rights, please contact our privacy officer.

Use and Disclosure of Protected Health Information

In order to effectively provide care, there are times when we will need to share your personal health information with others beyond the urgent care practice for:

Treatment: With your permission, we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including but not limited to, sharing information with others outside the urgent care practice that we are consulting with or referring you to.

Payment: Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Information Disclosed Without Your Consent

Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow-up Appointment/Care: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that be of interest to you.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors: We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purpose of carrying out their duties.

Government Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.
There also might be a need to state information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information if requested with the Department of Health and Human Services to determine our compliance with Federal laws related to health care.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

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Patient Rights and Responsibilities
You have the following rights under State and federal Law:

Copy of Record: You are entitled to inspect the personal health record we have generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records: You may consent in writing to release your records to others for any purpose you choose. This could include your attorney, employer, or others who you wish to have acknowledge your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record: You may ask us not to use or disclose part of the personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.

Contacting You: You may request that we send information to another address or by alternate means. We will honor such request if it is reasonable, and we are assured it is correct. We have the right to verify that the information you are providing is correct.

Amending Record: If you believe that something in your record is incorrect or incomplete, you may request we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment, you have the right to file a statement that you disagree with us. We will then file our response and your statement, and our response will be added to your record.

Accounting for Disclosures: You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operation purposes or that we shared with you or your family, or information we were required to release. We will notify you of the cost involved in preparing this list.

Questions and Complaints: If you have any questions or wish to receive a copy of this policy or have any complaints, you may contact us in writing for further information. You may also complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filling a complaint.

Changes in Policy: This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.

IMPORTANT: Read all sections before signing.

I acknowledge that I have received and read this privacy policy.

X_____ _____

Signature of Patient, Parent/Guardian or Responsible Party Date

_____

Printed Name of Responsible Party

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Authorization and Release

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

I authorize this urgent care center to send digital outreach regarding billing and other administrative matters, in order to enhance and expedite matters related to my healthcare services.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or to any other third-party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, coinsurances, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for all services. Insurance is a method for reimbursing patients, not a substitute for payment. We will be happy to complete and submit all insurance claim forms. Treatment costs not covered by insurance will remain your responsibility. After all insurance claims have been processed, we will bill you for any remaining amount. **Accounts 60 days past due from the date of the bill will be referred for collection.**

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer, if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy practices of Kathy's Urgent Care.

I understand a copy of this agreement may be used with the same effectiveness as the original.

Visit Follow-up Communication:

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience Kathy's urgent Care may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below, you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

(1) Use a password on your mobile device to prevent strangers from seeing what is on your phone.
(2) Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.
(3) If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely but will make it hard for others to see them.

X_____ _____

Signature of Patient, Parent/Guardian or Responsible Party Date

_____

Printed Name of Responsible Party

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Authorization for Guarantee of Payment

1. I understand that I am financially responsible for, and agree to pay, all of the charges that are not paid or billed to insurance or to any other third-party payer.

2. If I have no insurance or if my insurance is not accepted, I agree to pay in full today for all services rendered.

3. I agree that, if my insurance is accepted, I must pay all applicable co-payment, coinsurance, and deductible amounts today. If Kathy's Urgent Care is unable to verify my insurance at the time of service, I will pay in full for all services.

4. After all insurance claims have been processed, I agree to pay any amount that is not paid by insurance and billed to me. **I understand further those accounts 60 days past due from the date of the bill will be referred for collection.**

X_____ _____

Signature of Patient, Parent/Guardian or Responsible Party Date

_____

Printed Name of Responsible Party