WEXFORD HEALTH SOLUTIONS, LLC

484 Williamsport Pike
Box 151
Martinsburg, WV 25404

www.wexfordhealthsoutions.org
Tel: (716) 574-1543
Email: help@wexfordhealthsolutions.com

New Patient Welcome:

We are honored that you have chosen Wexford Health Solutions for your healthcare needs. Our commitment is to deliver timely, exceptional care, tailored to elevate your physical health and mental well-being. Led by Board-Certified Family Physician Dr. Nilay Thaker, our dedicated team ensures personalized attention and fosters respectful, professional relationships with each of our patients.

Please fill out the information accurately and completely. This will help Wexford Health Solutions provide you with the best possible care. By listing your emergency contact, you are giving us permission to contact them regarding your care.

Personal Information:

First Name: _____ Last Name: _____
Cell Phone: _____ Gender: _____
DOB: _____ Email: _____
Height (in): _____ Weight (lb): _____

Address: _____
City: _____ State: _____ Zip Code: _____

Emergency Contact:
Full Name: _____ Cell Phone: _____

Preferred Pharmacy:
Name: _____ Phone: _____
Address: _____

IMPORTANT: It is the patient's responsibility to ensure that their chosen pharmacy has the medication in stock and will honor prescriptions from Wexford Health Solutions. This will avoid delays and ensures a smooth process in obtaining your medications in a timely manner.

Medical History:

Please list medical conditions you have been diagnosed with, and any surgeries you have had.

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

Current Medication List:

Please list all the medications you are currently taking, including over-the-counter products, supple ments, and vitamins. Include the name of the medication, dosage, and frequency.

1. Medication: _____ Dose: _____ Frequency: _____
2. Medication: _____ Dose: _____ Frequency: _____
3. Medication: _____ Dose: _____ Frequency: _____
4. Medication: _____ Dose: _____ Frequency: _____
5. Medication: _____ Dose: _____ Frequency: _____
6. Medication: _____ Dose: _____ Frequency: _____
7. Medication: _____ Dose: _____ Frequency: _____
8. Medication: _____ Dose: _____ Frequency: _____

Allergies:

Please list all allergies and subsequent reactions.

1. Allergy: _____ Reaction: _____
2. Allergy: _____ Reaction: _____

Other Care Providers:

1. PCP Name: _____ Phone: _____

   Address: _____

2. Therapist Name: _____ Phone: _____

   Address: _____

Practice Overview:

At Wexford Health Solutions, we prioritize evidence-based, patient-centred care, focusing on your health and comfort. Our holistic approach to wellness is supported by comprehensive medical services and individualized attention.

All communication to the practice should be via:

Email: help@wexfordhealthsolutions.org

Phone Call or Text: (716) 574-1543

Practice Policies:

1. **Accurate Completion of Initial Intake Form:**
   An accurate and complete initial intake form, should be signed and send before your appointment . Your submission indicates your consent to treatment by Dr. Thaker and any practitioner at Wexford Health Solutions.

2. **Fee Structure:**
   Initial visits are $175 and follow-up visits are $115. Wexford Health Solutions is a Concierge Family Practice, and we do not accept insurance.

3. **Payment Methods:** Wexford Health Solutions, LLC utilizies Square Payments, a fully secure and HIPAA-compliant system, accepting credit or debit cards. Full payment is due at the time of appointment booking.

4. **Appointment Requests:** It is the patient's responsibility to use the practice website to make timely appointments, ensuring continuity of care. It is suggested to book a follow-up appointment upon completion of a visit.

5. **Reschedule/Cancellation Requests:** An appointment may be changed or canceled by clicking the reschedule / cancel link at the bottom of your Square Confirmation Email, or by emailing the practice. We request a minimum of 24 hrs notice for cancellations. Failure to do so will result in a $50 cancellation fee.

6. **No-Show Policy**: Respect for your time and ours is paramount. Failure to attend an appointment without prior notification will result in a $50 no-show fee. Repeated instances of no-shows may lead to discharge from the practice

7. **Work or School Excuse Notes:** If you require a formal excuse letter for medical necessity, please request it during your visit, or send an email to the practice. Kindly allow a turnaround time of 72 hrs. The fee for this service is $25.

Prescription Policies:

Medication Management: We require a comprehensive medication list to be reviewed and updated annually or as necessary.

- It is recommended that patients utilize one pharmacy exclusively. If medications need to be sent to a different pharmacy for any reason, you may email the practice. Please allow a turnaround time of 72 hrs.

- If you need to speak with a member of our staff between appointments, you may email your concerns to the practice or call/text our office at (716) 574-1543. Kindly allow a turnaround time of 72 hrs. Please refrain from contacting Dr. Thaker directly.

Controlled Substance Agreement: You agree to adhere to the following guidelines:

- Refrain from obtaining additional controlled substances from other healthcare providers while you are under our care. If such medications have been received elsewhere please notify us promptly

- Please notify Wexford Health Solutions of any hospital admissions, ER visits, urgent care visits, new outside providers, and hospitalizations.

- Monthly follow-up appointments are mandatory for controlled substance refills.

- Controlled drugs will not be refilled sooner than 28 days from the date on th e original prescription, without any exceptions.

- Our practice does not prescribe opioid medications, except on rare occasions.

Failure to adhere to these guidelines may result in discharge from our practice.

Consent for Treatment:

I, _____, hereby consent to receive medical treatment from Dr. Nilay Thaker and any practitioner at Wexford Health Solutions. I attest that the information provided in the intake form above is true and accurate to the best of my knowlege. I understand that medical treatment involves certain risks and hereby release Dr. Thaker, Wexford Health Solutions, its employees, and affiliates from any liability arising from the provision of medical care, except in cases of gross negligence or willful misconduct.

Signature: _____ Date: _____

Acknowledgment of Policies:

I have read and understood the policies outlined above. I acknowledge receipt of this information and agree to abide by the policies set forth by Wexford Health Solutions.

Signature: _____ Date: _____