PATIENT INFORMATION

First Name: ________________________ MI: ___ Last Name: ______________________ SSN#:____________________

Date of Birth: ___________ Age: ______ Sex: ____ Gender Identity: ___________Sexual Orientation: _______________

Marital Status: S___ M___ D___ W___ Email Address: ____

Race: _________________________ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: ____________

Street Address: __________________________________ Mailing Address (If Different):__________________________

City: _____________________________ State: _________________________ Zip Code: _________________________

Home Phone: ____________________________________ Mobile Phone: _______________________________________

Work Phone:_____________________________________ Employer:____

ACCOUNT RESPONSIBILITY (If different than above)

Is this a Workman Comp claim? Y / N *If yes, we will need a referral from your employer and claim information.*

Who is responsible for this account? ________________________________ Relationship to patient: ________________

Mailing Address: ____ City: ______________________ State: _________

Cell Phone: __________________ Home Phone: __________________ Date of Birth: __________SSN#: _____________

MEDICAL INSURANCE

Name of Primary Insurance Company: ____

Subscriber Name: ____ Group # ____________________________

Member ID: ______________________________________ Subscriber Date of Birth: _____________________________

Name of Secondary Insurance Company: ____

Subscriber Name: ________________________________ Group # ________________ Member ID: ________________

Subscriber Date of Birth: ______________________ Medicare ID (If on Medicare): _______________________________

CASH PAY POLICY

Patients without medical insurance will receive a 45% self-pay discount. Full payments for services rendered are expected at the time of service.

By signing below you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: ____ Date: _________________

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to NC WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service. <u>If you do not have your co-pay when you check in, we will need to reschedule your appointment for another time.</u>

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office. For questions regarding your bill, you can call 252-809-6463.

4. Williamston Clinic Corporation and its affiliated clinic practices and/or contracted business associates may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Williamston Clinic Corporation and its affiliated clinic practices and/or contracted business associates to call you at any telephone number provided or obtained, without limitation of wireless. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

5. A **$25.00 fee** will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from the practice.

6. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you are subjected to be discharged from any of the affiliated clinic practices within the Williamston Clinic Corporation.

7. If you arrive more than 15 minutes late to an appointment, you may be asked to reschedule. Each provider may have a separate no-show policy.

8. All clinics and practices require **two business days** to respond to all medication refill requests. Medications will not be refilled after clinic hours. You may contact your pharmacy or go through the patient portal to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, you state that you have read and understand the above **CLINIC BILLING AND EXPECTATIONS.**
I am requesting that Williamston Clinic Corporation and its affiliated clinic practices to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Williamston Clinic Corporation and its affiliated clinic practices does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):____Date of Birth: _________________

Signature (Patient/Guardian): _______________________________________Date:_________________________

Acknowledgment Privacy Policy Offered

My health information may be created or reviewed by Williamston Clinic Corporation and its affiliated clinic practices and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Williamston Clinic Corporation and its affiliated clinic practices will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Williamston Clinic Corporation and its affiliated clinic practices and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of the Williamston Clinic Corporation and its affiliated clinic practice's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of the Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Name (Please Print):____ Date: _______________________

Signature (Patient/Guardian): _______________________________________ Date: _______________________

Witness: ____ Date: _______________________

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) give you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Williamston Clinic Corporation and its affiliated clinic practices to leave messages regarding:

☐ Appointments ☐ Billing information ☐ Patient Surveys

☐ Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

☐ **Home** ☐ **Mobile** ☐ **Work**

If you have someone you would like to add to receive messages on your behalf, please complete the information below:

Name:______________________________ Relationship: ___________ Phone number:_________________

This release will be revoked by written permission only. I understand that I must send a written request to Williamston Clinic Corporation and its affiliated clinic practices in order to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Patient Name (Please Print):____ Date: ______________________

Signature (Patient/Guardian): _______________________________________ Date: ______________________