PATIENT REGISTRATION FORM

Well Being-Being Well 6862 Elm Street #720 McLean, Virginia 22101 703-635-2158 FAX 703-356-1610

PLEASE PRINT

Patient Name: _____ Name you prefer to be called: _____

Home Address:

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Gender: ❑ Female ❑ Male Social Security #: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Committed Relationship

Email Address: _____

Referring Physician: _____ Would you like us to send a letter regarding your treatment to this physician? ❑ Yes ❑ No

How did you find us? ❑ Friend: _____ ❑ Internet/Web ❑ Mary Shomon's website ❑ Dr Kate's Website ❑ Dr. Adrienne's Website

Financially Responsible Person: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Name: _____ Phone: ❑ Home ❑ Work ❑ Cell _____

Address: _____ Responsible Party's Signature: _____

Responsible Party's Employment Status: ❑ Employed ❑ Retired ❑ Full-time Student Employer: _____

Emergency Contact: ❑ Same as Financially Responsible Person Relationship: _____

Name: _____ Phone: ❑ Home ❑ Work ❑ Cell _____

Address: _____

I certify that I DO NOT have Medicare or Medicaid Coverage. Please initial: _____

I understand that the physicians at Well Being-Being Well have opted out of Medicare (see Medicare Patient Contract): Please initial: _____

I certify that I AM NOT seeking treatment for a work-related accident of occupational disease that might be covered under a worker's compensation plan provided by my employer. Please initial: _____

Insurance Information:

Primary Medical Insurance Company:
Address: _____ Phone: _____
Insured / Card Holders Name: _____ Relationship: _____ Insured's Date of Birth: _____
Policy #: _____ Group #: _____ Group Name: _____

WELL BEING-BEING WELL NEW PATIENT FORMS

I voluntarily present myself for treatment at Well Being-Being Well, LLC, and I herby authorize my physicians and such associates, assistants and designees as they may select and the staff, agents and employees to perform, and I herby consent to, such medical care, including diagnostic procedures, medical treatments and examinations, as may be necessary in the opinion of my physicians.

I hereby authorize Well Being-Being Well to apply for benefits on my behalf for services rendered. I understand that I can request price information for any services or purchases prior to the care being rendered so that I can make an informed financial decision.

Once care or purchases have been rendered, I understand I will be financially responsible for the amount charged.

I certify that the information I have provided is true and accurate.

I further authorize the release of any medical information or other information for this or any related claim to any insurance company.

I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked by me in writing.

I understand that I am financially responsible for *all* charges whether or not paid by insurance.

I understand there will be a statement charge of $5.00 each month I have an outstanding balance and a bill is sent to me.

I understand that if my balance remains unpaid for 45 days or more, it will be subject to an 18% annual interest rate, and if it becomes necessary to refer my account to a collection agency or an attorney.

I agree to pay the balance in full along with all the collection costs starting with an initial $15.00 collection fee and any or all legal fees relating to collecting the *entire* amount due on my account (all office visit charges, lab charges, lab interpretation fees, statement charges, etc).

I understand that these policies are subject to change at any time without notice.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Legal Guardian Date

_____

Printed Name of Legal Guardian or Parent

FINANCIAL POLICIES

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. The following is a statement of several important Well Being-Being Well policies, which we require that you read and sign prior to treatment.

Worker's Compensation: We cannot accept Worker's Compensation cases. If you have had a work related injury please contact your Worker's Compensation Insurance Carrier or your Primary Care Physician for an appropriate referral.

Fee for Service: FULL PAYMENT IS DUE AT THE TIME OF SERVICE—WELL BEING-BEING WELL ACCEPTS CASH, CHECKS, VISA, DISCOVER AND MASTER CARD. We *do not* accept American Express.

Returned Checks: There is a $50.00 fee for each returned check. If you have a check returned, for any reason, you will not be able to use checks for payment in the future.

Insurance Reimbursement/Covered Services: Your health insurance policy is a contract between you and your insurance company. Well Being-Being Well is not a party to that contract and does not accept assignment of benefits.

We do not participate with any insurance carriers including government insurance policies.

Electronic Claims Submission: As a courtesy we can send in your claim electronically if your insurance company is covered by our claims clearinghouse. Filing electronically can get your claim to the insurance company in several days.

Non-electronic Claims Submission: If you choose to submit your own claim or we are unable to submit your claim, you will be given two copies of your fee slip (one to submit, one to keep for your records). Please make sure to take a copy of your fee slip at the time of service. If you request additional copies of fee slips for past dates of service, there will be an initial $5.00-$15.00 search/handling charge, a standard copying charge, and postage charge if applicable.

Medicare: We cannot submit claims to Medicare (see Medicare Beneficiary Contract). Both physicians at Well Being-Being Well have opted out of Medicare.

Insurance Coverage: The fee slip provides standard information that insurance companies routinely require to process their reimbursement to you.

Non-covered Services: Please be aware that some, and perhaps all, services provided at Well Being-Being Well may be "non-covered" services, and therefore, may be deemed "unreasonable" or "unnecessary" by insurance programs. The Laboratory Interpretation Fee is not covered by many insurance companies. Some insurance companies will not consider our charges for payment such as HMO's, Medicare, etc. We urge you to contact your insurance company prior to treatment to learn what services your insurer will and will not cover.

Usual and Customary Rate (UCR): Well Being-Being Well is committed to providing the best treatment possible for our patients and we charge what we believe is a reasonable fee for the time and services provided. You are responsible for payment in full, regardless of any insurance company's determination of usual and customary rates. Please contact your insurance company regarding any reimbursement concerns.

Insurance Information Requests: If you insurance company requests information beyond that provided on your fee slip, such as copies of your medical records, we will bill your insurance company for the cost of providing such information and send the requested information upon receipt of payment. If you insurance company does not pay the cost of such requested information you may be billed for the copies. If your insurance carrier requests extensive about your care we will notify you of any additional charge for providing the needed information. We urge you to read very carefully any

forms you sign to release your medical information to an insurance broker or insurance agency.

Release of Protected Health Information: We will provide you with a release form to send your medical records to other physicians or entities. If you sign a form with another company or broker, please read those forms carefully. Please understand that you have a right to restrict the information sent to these entities such as HIV status, Mental Health Records, etc. If you sign a form that does not restrict your Protected Health Information, we will forward all the records as indicated by the form you sign. We urge you to read every form very carefully before you request your records to be released.

Minor Patients: Minors must have permission from a legal guardian to be treated, except for exemptions provided by law. The Parent/Guardian accompanying a minor patient (and/or parent/guardian) is responsible for full payment at the time of service.

Vitamins/Supplements: Well Being-Being Well sells vitamins and supplements. We want you to know that the physicians do have a financial interest in the sale of these items. You do not have to purchase products from us and we will write out the appropriate information for you to find the supplements at another vendor.

Prescriptions: Well Being-Being Well will provide routine prescriptions during regular business hours Monday through Friday except holidays.

We need 48 hours or two regular business days to process prescription requests.

We encourage you to ask for your prescription refills at the time of your office visit.

In the case of an emergency and you require your prescription in less than 48 business hours we will charge you $25.00. There will also be a $25.00 charge for any routine prescriptions requested on the emergency line after regular business hours. Please be aware that our office is closed at 5:00 pm weekdays except the office closes on Thursday at 12 noon. We are closed on the weekends.

We ask that you call our office during regular business hours and leave all the information needed to provide your refill (Your Full name, a phone number where you can be reached if there is a question about your prescription, your date of birth, Pharmacy name. phone number and fax number with area code, medication, dosage, how you take the medication, quantity of medications you are requesting) please be aware that if you do not leave the appropriate information or do not speak clearly on the answering machine, your prescription could be delayed. There will be a $25.00-$150.00 charge for pre-authorizing a medication or test with your insurance company, this charge is based on staff time spent with the insurance company.

Laboratory / Test Orders: We provide you with a prescription for lab work or testing that will be performed outside of our office. If you have lost your prescription and need a replacement prescription urgently (within 24 hours), there will be a $35.00 replacement fee.

Phone Calls / Portal Messages: If a phone call or portal message with/to the physician or the nursing staff extends beyond 5 minutes of time, it will be considered a medical phone visit / portal visit and you may be charged according to time. Please be aware that phone/portal consultations/visits may not be covered by your insurance company, so we encourage you to verify your insurance coverage for these services before having them performed. You will need to provide information for payment for phone / portal visits/consultations at the beginning of the appointment.

Deemed Consent: The situation may arise where a staff member has been exposed to my body fluids. I understand that the laws of Virginia provide that my physician or any person employed by or under the direction and control of my physician may be directly exposed to my body fluids in a manner which may, according to the current guidelines of the Centers for Disease Control, transmit the human immunodeficiency virus (HIV), Hepatitis virus, or other communicable disease. If this situation occurs, I authorize Well Being-Being Well, LLC to perform any required laboratory tests as ordered by the physician. I further understand that by law I will be deemed to have consented to release of any related test results to the person exposed to my body fluids.

Please let us know if you have any questions or concerns about Well Being-Being Well's billing policies or procedures. I understand that these policies and procedures are subject to change at any time without notice.

I have read these policies, and I understand and agree to them.

Signature of Patient or Responsible Party Date

Well Being-Being Well Appointment Cancellation Policy

Reminder Calls: As a courtesy to our patients, our computer system makes reminder calls for physician visits, laboratory work reminders, nurse visits, and Laboratory work visits. This service is done as a courtesy only and does not negate your responsibility for keeping your scheduled appointments. You will be responsible for the late cancellation charge if you miss a scheduled appointment or cancel late regardless of whether you received this courtesy call.

Charge for Missed Appointments: Unless canceled at least *2 business days* in advance, you will be charged a minimum of $50.00 or up to the entire cost of the visit for a missed appointment. Please help us serve you better by keeping your scheduled appointments.

Charge for Missed Appointment if follow up testing ordered has not been performed:

Testing Not Performed: If you cancel an appointment *5 business days* in advance because you have not performed follow up testing as ordered by your physician you will be charged a minimum of $50.00 or up to the cost of the entire visit.

Follow up Testing is Critical: Many of our patients are being treated for conditions where follow up laboratory work is critical for providing quality health care such as deciding what medication type or dosage to order, etc.

Prescriptions in limited quantity until test results are received: If you must cancel your appointment and have not had your laboratory work performed, you may be asked to schedule an urgent blood draw and you will be given a limited quantity of your medication until those lab results can be returned to the physician for review with you at a scheduled appointment time.

Call Us Before Your Test Results Are Due: We will be working with you to provide you health care and will be ordering what we believe is best for your health. We believe performing testing/laboratory work is extremely important. If you have a concern or issue about having the ordered lab work performed, please call our office and discuss your concern with the nurse or physician prior to the date the follow up testing or laboratory work is due.

Non-Compliance Can Lead to Discharge: Non-compliance with getting your laboratory work or keeping the recommended appointments, may be detrimental to your health and could result in being discharged from the practice.

I have read the Appointment Cancellation Policy, and I understand and agree with them.

_____ _____

Signature of Patient or Responsible Party Date

WELL BEING-BEING WELL

TRICARE/INSURANCE WAIVER

Patient Acknowledgement:

I acknowledge that I have been informed that the service fees at Well Being-Being Well, LLC could be non-covered or exceed the allowable Tricare or other Insurance company's fee schedule.

I understand that Well Being-Being Well, LLC does not participate with *any* insurance companies and that payment for services are due at the time of the visit.

I agree to pay for the services at Well Being-Being Well at the time of service including those services not covered or that exceed the Tricare or other insurance company's allowable fee schedule

I have read the Tricare/Insurance Waiver and I understand and agree to the above.

Signature of Patient or Responsible Party Date

Patient Name Printed:_____

Guardian Name Printed:_____

Well Being-Being Well

LABORATORY INFORMATION SHEET

In order to serve you better we provide laboratory services in our office.

If you choose to go to an outside laboratory you are responsible to assure the lab results arrive to our office prior to your scheduled appointment.

Our laboratory fee schedule is designed to include the physician interpretation of lab values. You will be assessed a laboratory interpretation fee for laboratory testing done outside of our office. This charge will be based on the amount of physician time required to interpret the lab results and will vary depending on the complexity of the lab data (range $50.00-$200.00).

Please be aware that many insurance companies do not provide coverage for this service. We will be unable to appeal a non-covered service. We encourage you to check with your insurance company about coverage.

I have read and understood the Laboratory charge information above:

_____ _____

Patient Signature Date

_____ _____

Legal Guardian or Parent Date

_____

Printed Name of Legal Guardian or Parent

Well Being- Being Well New Patient Forms

Well Being- Being Well, LLC

MEDICARE BENEFICIARY CONTRACT

This agreement is between Adrienne J. Clamp, M.D. ("Physician"), whose principal place of business is Well Being- Being Well, LLC 6862 Elm Street Suite 720 McLean, VA 22101 and

Patient _____ ("Patient"),

who resides at _____and

❑ **IS** a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997

OR

❑ **IS NOT** a Medicare Part B beneficiary at this time but may seek services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 in the future.

The Physicians at Well Being-Being Well have informed the Patient of the office's Opt Out Policy. Dr. Adrienne Clamp will continue to Opt Out of the Medicare Program until the office notifies the patient in writing of a change in this status. If the patient has a question about Dr. Adrienne Clamp's status in the Medicare Opt Out Program they should address their question in writing to: Office Manager, Well Being-Being Well LLC 6862 Elm Street #720 McLean, VA 22101. The patient will receive a reply in writing. Patient's use of Medicare is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

Medical Care	**Acupuncture**	**Inhalation Treatment**
Injections	**Immunizations**	**EKG**

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Practice's Current Fee Schedule (which is available upon request). Patient also agrees, understands and expressly acknowledges the following:

Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.

Patient is not currently in an emergency or urgent health care situation.

Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.

Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare- covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

Patient acknowledges that a copy of this contract has been made available to him/her at their request.

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by _____(Patient Name)
and Adrienne J. Clamp, M.D. [Physician],

_____

Patient Signature

_____

Dr. Adrienne J. Clamp Signature

Well Being- Being Well, LLC
MEDICARE BENEFICIARY CONTRACT

This agreement is between Kathryn A. Lemmerman, M.D. ("Physician"), whose principal place of business is Well Being- Being Well, LLC 6862 Elm Street Suite 720 McLean, VA 22101 and
Patient _____ ("Patient"),
who resides at _____and

❑ **IS** a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997

OR

❑ **IS NOT** a Medicare Part B beneficiary at this time but may seek services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 in the future.

The Physicians at Well Being-Being Well have informed the Patient of the office's Opt Out Policy. Dr. Kathryn Lemmerman will continue to Opt Out of the Medicare Program until the office notifies the patient in writing of a change in this status. If the patient has a question about Dr. Kathryn Lemmerman's status in the Medicare Opt Out Program they should address their question in writing to: Office Manager, Well Being-Being Well LLC 6862 Elm Street #720 McLean, VA 22101. The patient will receive a reply in writing. Patient's use of Medicare is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

Medical Care	**Acupuncture**	**Osteopathic Manipulative Therapy**
Injections	**Immunizations**	**EKG**
Inhalation Treatment		

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Practice's Current Fee Schedule (which is available upon request). Patient also agrees, understands and expressly acknowledges the following:

Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.

Patient is not currently in an emergency or urgent health care situation.

Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.

Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare- covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

Patient acknowledges that a copy of this contract has been made available to him/her at their request.

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by _____(Patient Name)
and Kathryn A. Lemmerman, M.D. [Physician],

_____
Patient Signature

_____
Dr. Kathryn A. Lemmerman Signature

Well Being- Being Well, LLC

MEDICARE BENEFICIARY CONTRACT

This agreement is between Elizabeth T. Conrad, M.D.. ("Physician"), whose principal place of business is Well Being- Being Well, LLC 6862 Elm Street Suite 720 McLean, VA 22101 and
patient _____
("Patient"), who resides at _____and

❑ **IS** a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997

OR

❑ **IS NOT** a Medicare Part B beneficiary at this time but may seek services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997 in the future.

The Physicians at Well Being-Being Well have informed the Patient of the office's Opt Out Policy. Dr. Elizabeth T. Conrad will continue to Opt Out of the Medicare Program until the office notifies the patient in writing of a change in this status. If the patient has a question about Dr. Elizabeth T. Conrad's status in the Medicare Opt Out Program they should address their question in writing to: Office Manager, Well Being-Being Well LLC 6862 Elm Street #720 McLean, VA 22101. The patient will receive a reply in writing. Patient's use of Medicare is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

Medical Care	**Acupuncture**	**Osteopathic Manipulative Therapy**
Injections	**Immunizations**	**EKG**
Inhalation Treatment		

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Practice's Current Fee Schedule (which is available upon request). Patient also agrees, understands and expressly acknowledges the following:

Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.

Patient is not currently in an emergency or urgent health care situation.

Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.

Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare- covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

Patient acknowledges that a copy of this contract has been made available to him/her at their request.

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____by _____(Patient Name)
and Elizabeth T. Conrad, M.D. [Physician],

_____
Patient Signature

_____
Dr Elizabeth T Conrad

WELL BEING-BEING PATIENT PORTAL AGREEMENT

Well Being-Being Well is providing a patient portal for the limited use of communicating with patients about their health care.

I understand:

I *cannot use* the portal to communicate an emergency*: Patient Initials:_____I
cannot use the portal to communicate about a pregnancy*:Patient Initials:_____
I *cannot use* the portal to communicate about a HIV or STD's*: Patient Initials:_____
I *cannot use* the portal to communicate about a mental health concerns*: Patient Initials:_____

I can use the portal to:

Request a prescription refill
Ask appropriate medical questions (see above limitations and below*)
Request laboratory results
Request test results
Request to make or change an appointment (not a same day appointment)
Receive appointment reminders
Pull my health summary for continuity of care with other health care providers
Provide information to update my health information
Provide information to update my personal information (address, phone numbers, etc)
Ask billing questions
I understand there may be a charge if I have an extensive number of questions, I am aware I will be made aware of this charge by the physician before my questions are answered. Patient Initial: _____
I understand that all communications via the Patient Portal will be included in my permanent medical record and cannot be removed or altered. Patient Initial:_____
I understand that all communications sent through the Patient Portal will be encrypted. I understand that Well Being-Being Well will make every effort to ensure my messages are secure. I understand that I am responsible for keeping my password and login confidential. I understand that communicating via the Patient Portal involves transmitting protected health information over the Internet and even though the information is encrypted there is a risk of the information being intercepted by non-authorized individuals. By using this portal I am accepting this risk. Patient Initials:_____
I understand if I believe someone has learned my password, it is my responsibility to change it immediately.
I understand that the normal response time via the Patient Portal can be from 1-3 days. I understand for any urgent need or same day appointment, I need to contact the office directly by phone or call the physician on call. Patient Initials:_____
I understand that using the Patient Portal is an optional service and I do not have to participate
I understand I must notify Well Being-Being Well if my email address changes.
I understand that Well Being-Being Well may suspend or terminate this service at any time and for any reason. Patient Initials:_____

Procedure:
Review and sign this Agreement.
You will be sent a welcome message with a link to the Portal login screen (if you do not receive this welcome message in three business days please call the office)
The welcome message will include the directions on how to access the Patient Portal.

I understand that the procedures regarding the Patient Portal are subject to change without notice. Patient Initials:_____

By signing this consent form, I acknowledge that I have read, understood and agree to all of the above information. I acknowledge that I have asked and received answers to all the questions I have about Well Being-Being Well's Patient Portal Policies and how to correctly utilize the Patient Portal before signing below.

_____ _____
Patient Name (Print) Patient Email

_____ _____
Patient Signature Date

PRESCRIPTION MEDICATION HISTORY CONSENT FORM
PHARMACY LISTING

The Providers at Well Being-Being Well, LLC use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection RX Hub / Sure Scripts which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us, your specialists and other providers, we ask that patient allow us to access their entire medication history through the RX Hub/Sure Scripts. This is done for your safety.

I consent to allow the providers at Well Being-Being Well to access all of my medication history including via the Virginia Prescription Monitoring Program (PMP).

PHARMACY LISTING:
To ensure we have your correct pharmacy information please provide the following information below:
GENERAL PHARMACY:
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy FAX:_____

COMPOUNDING PHARMACY:
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy FAX:_____

MAIL ORDER PHARMACY:
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy FAX:_____

_____
Signature

_____
Printed Name

_____
Date

PATIENT HISTORY FORM

Name: _____DOB:_____Date: _____

ALLERGIES:

List Medications and the allergic reaction you experienced:

_ _____

_____

_____

_____

_____

Environmental Allergies:___

❑ Seasonal (occur in specific seasons only)_____

❑Perennial (all year/several years)_____

CURRENT MEDICATIONS: Prescription Medications

Medication Name:	**Strength Form** **(liquid, tablet, etc)**	**Frequency you take the medication/ Number you take**	**Reason for medication:**	**Prescribed by which doctor:**

OVER THE COUNTER SUPPLEMENTS AND VITAMINS:

NON -PRESCRIPTION MEDICATIONS: include Over-the-Counter Medications, Herbs, Vitamins and any Dietary Supplements

Name:	**Strength Form** (liquid, tablet, etc)	**Frequency you take the medication/ Number you take**	**Reason for taking:**	**Brand Name:**

Why did you come to see the doctor today?_____
When did this problem begin?_____
Have you ever been treated for this problem before?_____

Have you or anyone in your family ever been diagnosed with:
1) High blood pressure? Yes_____ No_____
2) Heart disease? Yes_____ No_____
3) Diabetes? Yes_____ No_____
4) Kidney disease? Yes_____ No_____
5) Thyroid disease? Yes_____ No_____
6) Weight gain/Loss problems? Yes_____ No_____
7) Hair, skin or nail problems? Yes_____ No_____
8) Autoimmune disorders? Yes_____ No_____
9) Cancer? Yes_____ No_____
10) High cholesterol? Yes_____ No_____
11) Neurological Problems? Yes_____ No
12) Muscular problems ?Yes_____ No_____
13)Abdominal Problems ? Yes_____ No_____
14) Ear, Nose or Throat problems ? Yes_____ No _____
15) Eye problems ? Yes_____ No _____

Have you ever had any surgery performed ? Yes_____ No_____
_____
_____

Have you ever been in the hospital overnight for any reason ?_____
_____
_____
_____

If you do not understand any of these questions, leave them blank and we will discuss them at your visit.
The nurse will go over your medical history in depth before you have your visit with the physician.

PRIMARY CARE PROVIDER:

List your primary care physician with phone number:_____

I understand the physicians at Well Being-Being Well will not be my primary care provider. I understand that the physicians at Well Being-Being Well recommend that I have a primary care physician and a physical examination every year with age appropriate testing. Patient Initials:_____

To the best of my knowledge I have provided complete and accurate information regarding my health history, allergies and current medication/ supplements that I am taking. If I remember any additional information I will contact Well Being-Being Well and provide that information in writing. If I change medications or supplements during the course of my treatment at Well Being- Being Well, I will notify Well Being-Being Well in writing as soon as possible to prevent any drug or supplement interaction.

_____

Patient Signature

_____

Date

Well Being – Being Well, LLC

6862 Elm Street #720
McLean, Virginia 22101

Notice of Patient Privacy Practices

Your Information. Your Rights. Our Responsibilities.

When you become a patient or a potential patient at Well Being-Being Well we will create a medical record for you. This record can be in either a paper format or an electronic format. Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this information is referred to as your Individual Identifiable Health Information ((IIHI) or Protected Health Information (PHI). This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: September 1, 2016
- Kate Lemmerman, MD is our privacy official and her address is 6862 Elm Street #720 McLean, Virginia 22101, the phone is 703-635-2158 and the fax is 703-356-1610.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WELL BEING- BEING WELL

I acknowledge that I have been provided the Well Being-Being Well Notice of Privacy Practices ("Notice"):

- It tells me how Well Being-Being Well will use my health information for the purposes of my treatment, payment for my treatment, and Well Being-Being Well health care operations.
- The Notice explains in more detail how Well Being-Being Well may use and share my health information for other than treatment, payment, and health care operations.
- Well Being-Being Well will also use and share my health information as required/permitted by law.
- Well Being-Being Well may also exchange my health information for treatment purposes when participating in Health Information Exchange (HIE).

  I consent to Well Being-Being Well using and disclosing my treatment records maintained by Well Being-Being Well for the purposes detailed in Well Being-Being Well Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(please print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or legal representative*)

*May be requested to show proof of representative status

Office use only

I attempted to obtain the patient's signature on this acknowledgement, but was unable to do so as documented below:					
Date attempted:		Name:		Reason:	

Well Being- Being Well New Patient Forms
PERSONAL REPRESENTATION DESIGNATION

- Federal law says that we cannot share your protected health information (PHI) without your permission except in certain situations. If you sign this form, you are giving us permission to treat the person(s) you name as your Personal Representative, and to share your health information with that person.
- You can name more than one person as your Personal Representatives.
- This Personal Representative Designation will last until you tell us you do not want us to treat the person(s) you name below as your Personal Representative any longer.
- Right to Revoke: If you decide you do not want us to treat the person(s) you name below as your Personal Representative any longer, sign the Revocation at the end of this form and give this form to us. Any revocation can only apply on and after the date we receive the Revocation. We cannot cancel disclosures made to the Personal Representative before receiving the Revocation.
- You can keep a copy of this Personal Representative Designation, and can contact our Privacy Officer to get a copy if you do not have one.

Last Name: First Name:

Date of Birth: SSN (last 4 digits): Phone:

I name the following person to act as my Personal Representative:

Last Name: First Name:

☐ This person has all the rights that I have regarding my health information that the WELL BEING-BEING WELL has.

☐ This person is acting as my Personal Representative only for these functions:

Term of Authorization: The WELL BEING-BEING WELL may share my health information from the date of this Personal Representative Designation until I revoke the Personal Representative Designation by signing the Revocation below, and giving the Revocation to the WELL BEING-BEING WELL.

Signature: Date:

REVOCATION: I no longer want the person named above to act as my Personal Representative.

Signature: Date:

Please send this **Personal Representative Designation** or **Revocation** to:

WELL BEING-BEING WELL, Privacy Officer: Adrienne Clamp, M.D. Address: 6862 Elm Street #720 Elm Street McLean, Virginia 22101	If you have any questions, contact the Privacy Office at the address to the left.

Office use only

☐	Authorization received by:		Date:	
☐	Revocation received by:		Date:	