WELL BEING-BEING WELL NEW PATIENT FORMS

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: _____ Referring Physician's Phone Number**:** _____

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

❑ Bredesen: RECODE ❑ Institute of Functional Medicine

❑ Other: _____ ❑ North American Menopause Society

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 (contact the office to request a copy of Medicare Contract to review prior to signing at your first visit): 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: _____

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.

WELL BEING-BEING WELL NEW PATIENT FORMS

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 AND MASTER CARD. We *do not* accept American Express or Discover cards at this time.

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 and you cannot submit claims to Medicare because all of the physicians at Well Being-Being Well have opted out of Medicare (see Medicare Beneficiary Contract for further details). If you are a Medicare beneficiary, please contact the office to obtain a copy of the Medicare Beneficiary Contract prior to your first visit.

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. 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.

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 my prescription history through RX Hub, SureScripts or the current electronic prescription program utilized by our Electronic Medical Record System.

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). I consent to allow the providers at Well Being-Being Well to contact pharmacies to obtain my prescription history.

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.

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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

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 / Guardian Name Printed:_____

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.

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 that several physicians at Well Being-Being Well are not accepting patients for primary care at this time. I understand that Dr. Shiffman is currently accepting primary care patients. 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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

See copy of the Well Being-Being Well Privacy Policy on our website (www.wellbeingdocs.com) or contact our office at (703)-635-2158 to obtain a printed copy.

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:	

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: Kate Lemmerman, MD 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:	

PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Well Being-Being Well now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Well Being-Being Well believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Well Being-Being Well via email or text messaging. Well Being-Being Well does not share the names, e-mail addresses, and/or telephone numbers of patients with third-parties or with any other patient.

Please print all information neatly and legibly.

Name _____

E-mail address _____

Cell Phone _____

- ❑ Yes, please sign me up to receive e-mail and text messaging confirmations.
- ❑ I do not wish to be contacted via email. (Text messaging only)
- ❑ I do not wish to be contacted via text messaging. (Email only)
- ❑ I do not wish to be contacted by either text messaging or email.

I hereby give Well Being-Being Well permission to send messages to me via email and/or text messaging as means of communication as indicated by my selection above. I understand that I may revoke this consent at any time by from Well Being-Being Well in writing or by other means available such as clicking “unsubscribe” at the bottom of emails, when available. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Well Being-Being Well.

Print Patient Name:_____

Signature: _____

Date: _____