Total Wellness Medical Care

Registration form

Today's date:	PCP:

Patient's last name: Patient's first name:	□ Mr. □ Mrs. □ Ms. □ Miss	Marital Status: (circle one) Single/Married/Divorced/Separated/ Widowed

Is this your legal name? Yes or No	If not, what is your legal name?	Former name:	Birth date: ___/___/____	Age:_____ Sex: F or M

Mailing Address:	Phone number: ( ) Cell number: ( )	May we leave a message? Yes or no

Occupation:	Tell us how you heard about Total Wellness:

In case of Emergency:	**Phone number :( )**

Patient Medical History

Patient's Medical History: _____ _____ _____ _____ _____ _____	Patient's Medications: _____ _____ _____ _____ _____ _____
Patient's Surgery History: _____ _____ _____ _____ _____ _____	Patient's Allergies: _____ _____ _____ _____ _____ _____

Accident Information

Is this visit due to the result of an accident: □ Yes □ No **Date of Accident**: ___/___/____

Type of Accident: □ Auto □ Work □ Home □ Other **Attorney Name**: _____

With whom have you made an accident report?

□ Auto Insurance □ Employer □ Worker's Comp. □ Other

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Reason For Visit:_____ Area of Concern:_____

When did symptoms begins:
Type of pain: □ Sharp □Throbbing □Burning □Aching □Shooting □ Dull □Constant □Intermittent
□ Tingling □Cramping □Other:
Pain is usually Worse: □Morning □Afternoon □Evening □Anytime of day
Do any of the following make conditions worse: □Standing □Sitting □Walking □Bending □Lying down
□ Stretching □Exercise □Other:

What, if anything, relieves discomfort?

Onset of pain: □ Occasional □ Frequent □ Constant □ Worsening □ Improving
□ No Change
Severity of pain on a scale of 1-10 **(1) Mild to (10) severe**: _____
Context of injury, if known: _____
Prior studies of injury: □ None □ X-Ray □ MRI □ CT Scan □ Bone Scan □ EMG

Activities/ Hobbies/ Exercise: □ Continued with pain
□ Stopped due to pain

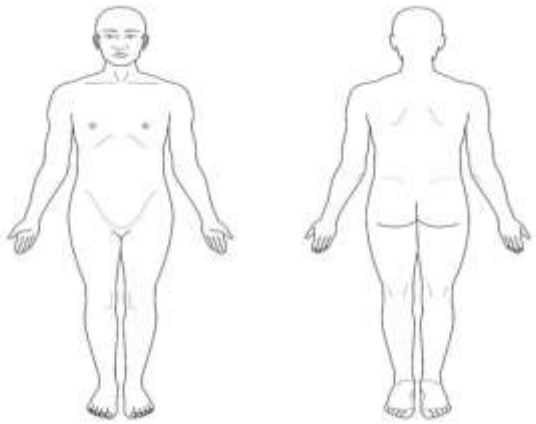
Associated Symptoms with your injury:

□ Weakness	□ Numbness	□ Tingling
□ Swelling	□ Redness	□ Warmth
□ Popping	□ Clicking	□ Catching
□ Instability	□ Grinding	□ Radiate down leg
□ Radiate down arm		

Please describe your work:

□ Unemployed	□ Regular Duty	□ Student	□ Modified Duty
□ Part Time	□ Full Time	□ Stay at home	□ Seated
□ Standing	□ Computer ____/hrs per day		
□ Light Physical	□ Heavy Physical		

Please indicate below the area(s) of concern:



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HIPAA RELEASE FORM
RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

□ Spouse:_____

□ Child(ren):_____

□ Other:_____

□ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.
Please call: □ my home _____ □ my work:_____ □ my cell:_____

If unable to reach me;
- □ You may leave a detailed message
- □ Please leave a message asking me to return your call
- □ Other:

The best time to reach me is on the following days, between the hours of: _____ and _____

Monday Tuesday Wednesday Thursday Friday

Signed: _____ Date: _____

Witness: _____ Date: _____

OFFICE VISIT NO SHOW POLICY

As part of our continued effort to provide you with the best care and to accommodate all appointment requests, we have implemented a Cancellation Policy. Time has been specifically reserved for your treatment, please call our office at (843) 261-8911 at least 24 hours prior to your appointment in order to cancel or reschedule.

If you fail to notify our office of your need to cancel or reschedule, or if you fail to show up for your schedule appointment, you will be charged a $30 or $50 for Specialist (Neurologist) fee. This fee will be added to your account and must be paid at or before your next appointment in order to receive treatment.

We understand that emergencies do happen and when such incidents do arise we will try and work with you. However excessive cancellations, no shows, and or emergencies will result in termination from our medical office.
Failure to sign this form will result in your inability to schedule running appointments therefore requiring you to schedule all appointments individually.

Signed:_____ Date: _____

Witness:_____ Date: _____

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LEGAL FORM: Authorizations, Assignments, and Releases

In consideration of Total Wellness, LLC undertaking care for me, I agree to the following:

1. Total Wellness, LLC is authorized to release/receive any information they deem appropriate concerning my physical condition to any insurance company, physician, and attorney in order to process my claim for reimbursement of charges incurred.

2. I hereby authorize and direct any insurance company and or attorney to pay directly to Total Wellness, LLC, and all such sums as may be owed for services rendered by reason of accident and to withhold such sums from any benefits I may be entitled to as a result of said accident. I agree that Total Wellness, LLC be given power of attorney to endorse sign my name on any drafts that are solely for the payment of their services.

3. As consideration for this agreement, Total Wellness, LLC will forgo demanding payment upon completion of each visit and will treat me without demanding payment until any insurance company has paid directly all sum due and owing. I understand that if I am not entitled to any sums paid by any insurance company total less that the amount of services rendered, I will be personally liable for any amount still owed. It is further understood that, if at any point the monies received exceed my indebtedness, those funds will be returned to me by a check from Total Wellness, LLC.

4. In the event any insurance company obligated to make payments to me or to you for charges made for your services refuses to make such payment upon demand by me or you. I hereby assign and transfer to Total Wellness, LLC any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action in my name or in the office's name. Furthermore, I authorize Total Wellness, LLC to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

CONSENT FOR TREATMENT

I, the undersigned, a patient at Total Wellness, LLC hereby authorize Dr. Rick Olson, Dr. Leo Jesion, Kelly Godin, FNP-C, and their staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment.

In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signed: _____ Date: _____

Witness: _____ Date: _____

CONSENT FOR TREATMENT OF MINOR

I, the undersigned, hereby authorize Dr. Rick Olson, Dr. Leo Jesion, Kelly Godin, FNP-C, and their staff to administer treatment as necessary to my child(ren). I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment.

Signed: _____ Date: _____

Witness: _____ Date: _____

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MEDICAL INSURANCE OR PERSONAL INJURY

□ **No**, I have not been involved in an accident

□ **Yes,** I am receiving treatment from Total Wellness Medical Care due to an injury caused from an accident. (If yes, please skip down to Personal Injury)

MEDICAL INSURANCE

Insurance based patients are required to pay their deductible unless there is a valid secondary policy in place. We will attempt to verify benefits upon your first visit; however, this can take several days to process.

If a policy deductible is in place, services will not be covered until that deductible has been met. Patients will be expected to pay deductible and/or Co-pay(s) at the time of service. Unpaid balances will be billed to the patient.

Please note:

- Total Wellness Medical Care DOES NOT promise that insurance will pay for your visit/s. Nor do the promise that an insurance company should pay the fees as charged.
- Total Wellness Medical Care will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's responsibility.
- If the patient has more than one insurance, that will need to be billed, Total Wellness Medical Care must know at the beginning of care.

Insurance comp name: **Insurance Policy #:**	**Policyholder name:**	**Policyholder date of birth:**

PERSONAL INJURY

□ All my claims will be billed through my medical insurance only

By acknowledging this document the patient agrees that they will only be using their medical insurance carrier to pay for treatment. If an attorney is obtained after treatments have begun, then the patient's medical insurance will no longer be billed. All bills from that point on will go directly through the attorney. We do not bill medical insurance and the attorney at the same time. At this point the patient is personally responsible for any remaining balance not covered by their medical insurance. At no time does Total Wellness Medical Care accept auto insurance as a form of payment.

□ I have retained an attorney

This process requires a Letter of Protection from the attorney prior to the patient's first visit. The Letter of Protection acknowledges that the patient had obtained an attorney and all claims will ONLY be sent to the attorney at the conclusion of treatments.

Should you have any payment questions, please feel free to consult with our billing manager.

Signed: _____ Date: _____

Witness: _____ Date: _____

Date of LOP received: _____

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Patient Rights:

As a patient you have the right to:

- Be treated with dignity and have your beliefs, cultural and religious practices respected
- Expect quality care based on recognized standards, practices, and ethics
- Know the identity, professional status, and qualifications of the professional responsible for your care
- Privacy during consultation and to have all information concerning you treated with confidentiality
- Have an advocate present at a consultation (ie: friend, family member and/or interpreter)
- Be actively involved in the decisions around the delivery of your care and participate in decision making which affects your care.
- Make an informed choice about appropriate treatment options and to consent to or refuse and assessment or treatment (unless legislation prevents this).

PATIENT RESPONSIBILITIES

As a patient it is your responsibility to:

- Treat staff with respect and courtesy
- Keep appointments or give early notification of cancellation
- Provide full and accurate information to the professional responsible for your care
- Respect the privacy of others attending this service and keep in confidence any information shared by group by group members in programs conducted by this service
- Tell staff if you do not understand what you have been told about your treatment and care.
- Accept the consequences of any decision you make not to adhere to agreed care plans that appropriate action may be taken.

Should you have any questions, comments, or concerns about anything concerning Total Wellness, LLC please let us know as soon as possible so that we can respond in a timely manner.

Total Wellness Medical Care
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