CLEWH New Patient Registration Form

Please read and fill out all areas to the best of your ability

Patient Information:

Date of Birth (mm/dd/yyyy): _____ Sex: (M/F) SSN:_____

Last Name: _____ (Legal) First Name:_____

Preferred Name (if different): _____

Address: _____ City: _____

State: _____ Zip: _____ How Did You Find Us? _____

Patient Contact Information:

Best Phone #: _____

(We call all scheduled appointments the day before unless already confirmed)

Email: _____

Preferred Method(s) of Contact and Appointment Reminder (Select all that apply):

_____ Phone Call _____ Text Message

_____ Email _____ I Do Not Want Reminders

Is it okay to leave a detailed voicemail message? ____ Yes ____ No

Do you receive transportation assistance? ____ Yes ____ No

If yes, please list their name/company: _____

Best phone number: _____

Emergency Contact Information:

Last Name: _____ First Name: _____

Phone Number: _____ Relationship: _____

Primary Care Information:

Physician Name: _____ Last Seen:_____

Clinic Location (Street/City): _____

___ Avera ___ Sanford ___ VA ___ Other (Please List:_____)

OR _____ I do not have a primary care physician

Preferred Pharmacy:

Pharmacy Name: _____

Location: _____

Release of Information (For treatment or other healthcare purposes):

The signature of this form authorizes the release or use of your personally identifiable protected health/medical information (PHI) by Center for Lower Extremity Wound Healing to carry out treatment or other healthcare operations. Please review the Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent form, and a copy is displayed on the wall near the front desk. A paper copy may be provided to you at your request.

We (Center for Lower Extremity Wound Healing) reserve the right to change the terms of our Notice of Privacy Practices at any time. If we do make changes to the terms of our Notice of Privacy Practices, you may obtain a copy of the revised notice by submitting a written request to our practice or by requesting one from our front desk.

You retain the right to request that we further restrict how your Protected Health Information (PHI) is released or used to carry out treatment or other health care operations. You may do so by writing to our office with such a request

Financial Responsibility Policy Acknowledgement

Insurance: CLEWH is contracted with many insurance providers, however we may be out of network with some providers or plans. **As an insurance holder, it is your responsibility to know your plan's network and coverage.** If your policy is out of network, we will collect self-pay fees.

CLEWH asks that you bring your insurance care to every appointment and inform us promptly of any changes to your coverage or policy. We will attempt to verify coverage prior to the appointment using the information that is provided to us. As a courtesy to the patient, insurance claims will be submitted on the patient's behalf based on this information. **The patient, responsible party, or guarantor is responsible for any balance remaining or not covered by the insurance policy.**

Any copay, as determined by the insurance provider, will be due upon checking in for that day's appointment.

Any patient without insurance will be subject to self-pay pricing. These prices will be presented to you upon self-pay determination. **Self-pay costs are due at the time of treatment.**

Auto-Payment Collection: To receive services at CLEWH, **a major credit/debit card is required to be kept on file.** A balance of $50 or less will be charged automatically and you will receive an e-notification 1 day prior to the payment processing. Balances greater than $50 may be paid electronically via online bill pay, or by calling our Billing Department or Office. We also accept cash, major credit/debit cards, and personal checks (NSF fee applies) for outstanding balances greater than $50.

If you have an outstanding balance with CLEWH, you be notified first by text or email. If no response is received, you will receive a paper statement. **Any balances that are outstanding for more than 90 days are eligible to be transferred to a collection agency.** If you would like to request accommodation for paying an outstanding balance, please contact our Office or Billing Department.

Additional Fees:

A $50 fee will be assessed on all returned checks

CLEWH reserves the right to charge a fee of $40 for completion of disability forms and/or other requested documentation that requires a significant amount of the doctor's and office manager's time to complete. CLEWH also reserves the right to take up to 30 days to complete these requests.

Late and No-Show Policy

When scheduling an appointment with CLEWH, we want to ensure enough time to provide you with the highest quality care. **We request that you arrive 15 minutes prior to your scheduled appointment time. If you are more than 10 minutes late to your appointment, we may ask you to reschedule to allow for sufficient time for your appointment without disrupting others' time.**

The health of our patients is important to us, and we want to provide availability so that our patients can be seen in a timely manner. Should you be unable to make it to your appointment, please call our office at least 24 hours prior to your scheduled time to cancel or reschedule. **If you fail to give 24 hours' notice or do not arrive at your scheduled appointment, a $50 fee will be posted to the patient's account (not billable to insurance) and run using the credit card on file. If this payment method fails, an alternative method must be used prior to scheduling a next visit.**

By signing below, I attest that the information provided on this form is true and accurate, and I agree to and understand the above policies.

Signature of Patient/Guardian: _____ Date:_____