WILLOW MEDICAL
& wellness

Patient Registration Packet

Date: _____ **Name:** _____
(Last) **(First)** **(Middle)**

DOB_____ Age_____ Male _____ Female_____Other:_____

Mailing Address _____
Address (City) (State) (Zip Code)

Physical Address_____
(if different than above) Address (City) (State) (Zip Code)

Home phone _____ Work phone _____ Cell _____

Email address_____Social SecurityNumber_____

Patient Employer _____ Insured's Employer _____

Insured's Name _____ Insured's Birth Date _____

Secondary Insured's Name _____ Secondary insured's Birth date _____

Additional family members who have permission to contact us regarding appointments

_____

Phone number we may use to contact you and leave messages : _____

Preferred method of appointment reminder (please circle): **Call**_____ **Text**_____ **or Email**_____
All appointments not confirmed will receive a reminder call the day before appointment.

Emergency contact people that we may call **without a release of information** should you require emergency care or intervention regarding your safety.

_____ _____
(Name) (Contact Number)

Minor Client Information:

First Guardian's Name: _____
(Last) (First)

Employer: _____ Relationship to client:_____SSN# _____

Personal Mailing address: _____City_____State_____Zip_____

Contact Number: _____ Work Number: _____

Second Guardian's Name: _____
(Last) (First)

Employer: _____Relationship to client: _____SSN# _____

Personal Mailing address: _____City_____State_____Zip_____

Contact Number: _____ Work Number: _____

Consent to Treatment

I consent to be treated and/or have my child treated by Willow Medical and Wellness. I hereby consent to any treatment or clinic services rendered to the patient under the general and special instructions of the provider and authorize any emergency first aid pending the instructions from the attending provider. I understand that I am fully responsible for all charges and fees for services rendered to me by Willow Medical and Wellness. I will pay my co pay, coinsurance or deductible at the time of my appointment unless other arrangements have been made. I authorize payment by my insurance company to pay directly to Willow Medical and Wellness. I authorize Willow Medical and Wellness to release necessary information to my insurance company to receive payment of claims. If my insurance company has not made payment within 90 days, I will provide full payment for services rendered, unless other arrangements are made.

_____ _____

Client or Parent/Guardian signature **(Date)**

_____ _____

Client or Parent/Guardian signature **(Date)**

INSURANCE BILLING IS PROVIDED AS A COURTESY. PLEASE BE SURE YOU HAVE CONTACTED YOUR INSURANCE FOR ANY PREAUTHORIZATION REQUIREMENTS AND TO DETERMINE YOUR BENEFITS.

YOU ARE REQUIRED TO KEEP OUR OFFICE UP TO DATE WITH YOUR CURRENT INSURANCE. IF YOUR POLICY CHANGES OR YOU ADD ADDITIONAL INSURANCE WE MUST BE NOTIFIED. WE WILL NOT BILL FOR CHANGES OVER 90 DAYS OLD.

Insurance information

Please provide a copy of your medical insurance card (front and back) and a photo ID to our front staff. To send electronically, you may use our UPLOAD link to send this information directly and securely to our office.

Primary Insurance Information:

Insurance Company _____ Policy Holder Name _____

Policy I.D. # _____ Group I.D. # _____

Policy Holder SS # _____ DOB _____

Relationship to client _____

Secondary Insurance Information:

Insurance Company _____ Policy Holder Name _____

Policy I.D. # _____ Group I.D. # _____

Policy Holder SS # _____ DOB _____

Relationship to client _____

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Medical Practice Commitments and Expectations

Welcome to Willow Medical & Wellness. Our primary goal is to provide all of our patients with the best care possible in an effective and efficient fashion. Establishing commitments and expectations at the start of our work together will ensure a mutually satisfying treatment relationship. Please review the following items and sign at the end of the document to indicate your agreement with the terms. If you have any questions or concerns, please let us know so that we may address them. Thank you.

_____ (Initial please) Keeping Appointment

Keeping appointments is integral to the treatment process. We recognize that things can come up and sometimes make it difficult to keep your appointment. Please let us know of this as quickly as you can so that we can reschedule your appointment and offer that time to another client. We do ask for one business days' notice (24 business hours) for a cancellation or rescheduling. (For example: If your appointment is Wednesday at 1:30pm we request that you call us by 1:30pm Tuesday. If your appointment is on Monday at 1:30pm and you need to call to cancel or reschedule please call by 1:30pm on Friday.) We consider a late cancelled appointment to be the same as a missed appointment. Reminder calls are made as a courtesy and are not guaranteed. **The fee's for a missed appointment or late cancellation as follows: $25, $50, $100. After three missed or late cancellations the fee will increase to 100% of the appointment fee.** It is ultimately up to each providers discretion, however, what to charge for no shows or late cancellations. It is our clinic policy to refer clients to other qualified providers when there have been three or more missed appointments or late cancellations. Should this occur, Willow Medical will be happy to provide referral names and contact numbers of alternative providers who may better suit your needs. In certain situations, a provider may elect to provide you with a 30-day supply of medications during your transition of care.

_____ (Initial please) Payment for Services

We require payment of the portion of your bill not covered by your insurance at the time of service. Once you have engaged our services, it is important to us that you are able to continue. If your financial situation changes, please let us know as soon as possible. We will attempt to work with you.

Returned checks will result in a charge of **$25.00**. If there are two returned checks on your account we will no longer be able to accept personal checks. If your account becomes over 60 days past due, ***we will expect you to set up a payment plan through our billing department.*** If your account is 90 days or greater past due, without significant effort to meet your obligation, we reserve the option to cease providing services for you. Late payment fees of **1.5%** per month will be charged on all account balances 90 days or greater past due. This fee will be charged each month to all balances past 90 days even if you are making monthly payments. Legal means to secure payment will be considered if necessary. This may involve hiring a collection agency, although we prefer not to use this option. All fees associated with this will be charged to the client. If your account is sent to collections we will no longer be able to continue treatment.

_____(Initial please) Non-covered Services or Charges

There will occasionally be charges that are not covered by individual insurance plans. These fees are your responsibility. We will attempt to bill insurance for all billable services, but if they are not payable by your plan you will be billed in full. Some of these services include but are not limited to telephonic services and on-line sessions.

_____ (Initial please) Prescription Refills

We request **four (4) business days notice** for all medication refill requests. Requests made on Friday's will not be reviewed until the following Monday. Please notify your pharmacy if you need a refill, and ask them to fax a refill request to our office. You may also call the clinic and leave a detailed message regarding which medication you would like your provider to call in for you. If problems arise, let us know. Certain medications cannot be faxed, phoned in, or refilled early (Scheduled IV medications such as stimulants). Planning ahead helps prevent you from running out of medications.

Dr. Ha, Dr. Rader and Dr. Johnson are in the office **Monday through Thursday.** Refill requests that are made on Friday are often unlikely to get filled until the following Monday.

Dr. Smith is in the office **Tuesday through Friday**. Refill request made on Monday's will be filled Tuesdays at the earliest.

We respectfully request that you make every effort to plan accordingly.

_____ (Initial please) Contacting the Clinic

You may reach us during business hours at (907) 222-0753. Our fax number is (907) 222-0754. Our hours of operation are Monday – Thursday 9:00 AM to 6:00 PM and Friday 9:00 AM to 5:00 PM. If we do not answer the phone during our regular office hours we are either on the phone or away from the desk momentarily. Please feel free to leave a message and we will get back to you as soon as possible.

If you are calling after hours, please leave a message and we will get back to you the next business day. Please note that we are closed all major holidays and are often closed the day prior or the day after depending on what day of the week the holiday falls on.

If you are experiencing a life-threatening emergency please call the **Community Crisis Line, at** (**907) 563-3200**, call 911 or proceed to the nearest emergency room. For non life-threatening urgent questions, an after-hours pager number for your provider will be available on our phone message (prompt #2). Pager coverage can be spotty in our large state. If you do not hear back within 2 hours of your page, please assume that they did not receive your page and call the Crisis Hotline. If you cannot safely wait, please utilize the emergency room, 911 or the community crisis line.

_____ (Initial please) Purpose of Treatment

I understand that the purpose of my psychotherapy and/or pharmacologic treatment (if indicated) is for my personal emotional/ physical health & wellbeing. Treatment goals will be established between myself and my treatment provider during the intake process. My treatment is not intended to be used for *litigation* purposes. I agree not to request that my provider release my medical records for litigation purposes and I agree not to call him/her to serve as a witness in any litigation I am currently involved in or any litigation I become involved in, unless a prior agreement is made between myself and my provider.

_____ (Initial please) Collaboration of Care

Your providers may collaborate care between each other and with other providers in the office. The administrative staff may also be asked to coordinate care between clinicians in the office or outside of the office depending on what is needed, this may be calling other clinics for availability, sending referrals or requesting records as needed. No protected health information will be shared with outside providers without a signed ROI.

_____ (Initial please) Clinic Property

Willow Medical and Wellness is a smoke free property. Please refrain from smoking on the property. We also respectfully request that you refrain from bringing in any weapons onto the clinic premises as we do see children, adolescents, and many of our adult clients have significant trauma issues. If you have questions about this request, please bring this to the attention of your treating provider. Thank you.

_____(Initial please) No Surprises Act

OMB Control Number [0938-XXXX]
Expiration Date [01/01/2023]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.
Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
Make sure to save a copy or picture of your Good Faith Estimate.
For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [907-222-0753].

_____ (Initial please) HIPAA Notice of Privacy Practices

I hereby acknowledge receipt of Willow Medical & Wellness Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

I HAVE REVIEWED THE COMMITMENTS AND EXPECTATIONS DOCUMENT AND AGREE TO ABIDE BY THEM WHILE I AM WORKING WITH WILLOW MEDICAL& WELLNESS.

_____
Client/Guardian Signature Date

Updated 03/29/2022