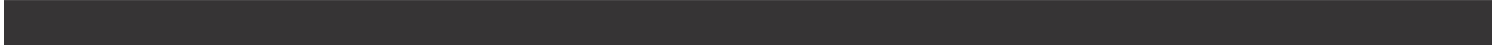




# Wake Internal Medicine Consultants, Inc.



## Patient Information

Chart: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (Primary): \_\_\_\_\_ (Secondary): \_\_\_\_\_

Cell Phone for receiving text messages: \_\_\_\_\_ Email: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: M F Marital Status: M S Other

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

*Please note that these questions are being asked in compliance with CMS Meaningful Use.*

Race:  White  Black or African American  Asian  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander  Declines to Provide

Ethnicity:  Hispanic or Latino  Non Hispanic or Latino  Declines to Provide

Language:  English  Other \_\_\_\_\_

Primary Physician (if seeing GI or GYN doctor): \_\_\_\_\_

How did you hear about us?  Physician Referral  Family/Friend  Other \_\_\_\_\_  
 Insurance Carrier  Direct Mailer  Google  WIMC Website  Yellow Pages  Yellowpages.com  Internet

Person to contact in case of emergency? \_\_\_\_\_

Emergency Telephone: \_\_\_\_\_

Preferred Pharmacy and Location: \_\_\_\_\_

Preferred Method of Contact:  primary phone  mail  email (patient portal-secure messaging)

### Responsible Party

Party responsible for payment: Self Spouse Parent Other

Name (if other than Self): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_

### Insured Party (Primary Card Holder)

Name: \_\_\_\_\_

SS# \_\_\_\_\_ DOB: \_\_\_\_\_

See other side ►

\_\_\_\_\_  
Initials By providing us your email address you are consenting to the use of secure messaging and our patient portal.

### **CREDIT POLICY**

\_\_\_\_\_  
Initials Wake Internal Medicine will be happy to file claims to your insurance company as a courtesy to you. However, seeing that your account is paid is your responsibility. We do expect timely settlement of your account, and payment at the time of service is expected. Any delinquent accounts may be reported to the Credit Bureau.

### **ASSIGNMENT AND RELEASE**

\_\_\_\_\_  
Initials I, the undersigned, understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Wake Internal Medicine Consultants, Inc. to release all information necessary to facilitate the processing of all claims related to my care. I authorize use of this signature on all my insurance submissions.

### **MEDICARE PATIENTS ONLY**

\_\_\_\_\_  
Initials I acknowledge that I have been informed of Wake Internal Medicine Consultants non-participation with the Medicare Program and acknowledge that benefits will be paid to me unless otherwise prohibited by Medicare regulations. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I acknowledge my responsibility to pay the amount determined by Medicare to be my responsibility to Wake Internal Medicine Consultants, Inc. in full on the date the service is rendered or as soon thereafter as can be arranged by mutual consent.

\* **This does not apply to Wake Gastroenterology, Wake Women's Health, or Wake Non-Surgical Orthopedics**

### **PRIVACY POLICY**

\_\_\_\_\_  
Initials I hereby acknowledge receipt, before any medical services were provided, of a "Notice of Privacy Practices of Wake Internal Medicine Consultants, Inc." for protected health information. I acknowledge that I have been given the opportunity to ask any questions that I may have regarding such policy. I understand that WIMC may use or disclose personal health information relating to me for purposes of treatment, payment, and health operations as disclosed in the notice.

### **NO SHOW/LATE CANCELLATION POLICY**

\_\_\_\_\_  
Initials I acknowledge that Wake Internal Medicine reserves the right to charge a fee for missed appointments or procedures. A missed appointment is defined as failure to show for your scheduled appointment or a cancellation/reschedule within less than 24 business hours of the appointment time slot (GYN procedures: 2 business days, GI procedures: 4 – 7 business days). 2nd no-show/late cancel is charged at 2x amount, 3rd no-show/late cancel results in dismissal from the practice. This tabulation resets annually.

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_