Dear New Patient,

Thank you for inquiring about establishing care with our doctor.

All new patients must register and authorize WMP to treat them before making an appointment. Please complete our registration and release information forms attached.

You can submit the completed and signed forms directly and securely via fax to: **(678) 932-8113**

or by email to: **office@waterfallsmedicalpractice.org**

You can also call our office directly at (678) 932-8112 and then press option 2 to speak with our staff for new patient registration and prompt appointment.

Again, thank you and we look forward to caring for you!

Patient Demographic Form

Patient Name (Last, First) Date of Birth

Gender (M / F) SSN Occupation

Address

Email Phone #

Occupation/Employer Marital Status (M / D / W/ S)

Preferred Language (English/ Other)

Next of Kin/POA and relationship

Phone # Email

Primary Insurance Information/Name of insurance:

Member/Subscriber ID Group #

Subscriber DOB Policy Holder Name

Policy Holder SSN Relationship to insured

Primary Insurance Address

Insurance phone

Secondary Insurance Information/Name of Insurance

Policy Holder Name Date of Birth

Phone # Member/Subscriber ID SSN

Address of Secondary Insurance

Phone #

Pharmacy Name/ Information

Address

Phone #

Please sign the consent and release of information forms that follow. Thank you

Authorization and consent to treat to treatment

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and /or any of my insurance carriers will be made on behalf to the provider or supplier of any services furnished to me by that provider or supplier.
I authorize any holder of my medical information to release it to Waterfalls Medical Practice, PC (WMP), the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and /or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services.
If my insurance plan does not participate in the WMP network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment and Pre-certification

In consideration of services provided to me by WMP and its care centers, I agree to be financially responsible and to pay for all services ordered by my provider(s)
I understand that my balance due because of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and I agree to make all collection related charges.
I understand that if my insurance has a precertification or authorization requirement, it is my responsibility to notify the carrier of services ordered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As a WMP patient, I voluntarily consent to the rendering of such care and treatment as the WMP provider(s) and personnel, in their professional judgement deem necessary for my health and wellbeing.
My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted disease and/HIV, if a separate consent is not required by law), including but not limited to vaccine administration.
My consent shall also include the carrying out of the orders of my treating provider(s). I acknowledge that neither my WMP provider nor any care staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I agree and understand that WMP may contact me using automated calls, emails and text messaging sent to my mobile or landline device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communication from WMP.
I understand that I may voluntarily "opt in" to receive automated text message communications from WMP and its partners by informing my provider's staff or visiting "my profile" on my WMP patient portal and agreeing to any additional Terms and Conditions established by my mobile carrier.
I hereby acknowledge that I have received WMP financial policy and Notice of Privacy Practices. I agree to the terms of WMP financial policy, the sharing of my health information via Health Information Exchange (HIE) and consent to my treatment by WMP provider(s).

Printed Name of Patient

Patient Signature and Date

Patient Representative Name (if legal Representative signing)

Signature and Date of Patient Representative

Preferred Contacts

The HIPPA Privacy Rule gives individuals the right to direct how and where their healthcare Provider communicates with them such as corresponding correspondence to the individual's office instead of the individual's home.

Please indicate your preferred place and manner of communication. You may update or change at any time in writing.

Patient Name Date of Birth

SSN

I prefer to be contacted in the following manner (circle all that apply)
Home Telephone

- Ok to leave detailed message
- Leave message with call back number only

Cell/Mobile Phone

- Ok to text
- Ok to leave message with detailed information
- Leave message with call back only

Work Telephone

- OK to leave message with detailed information
- Leave message with call back number only

Written communication

- OK to mail to my home address
- OK to mail to my work/office address

Email

Other

WMP respects your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick up and scheduling appointments.
Please note however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Patient Signature/Date

Patient representative/legal guardian signature. Relationship

Date signed by representative/legal guardian

Medical and Financial Information Release form
(HIPPA release form)

Name Date of Birth

Release of information

I authorize the release of all my medical information including the physician's notes, immunization records, tests and pharmacy/prescription records as well as admission/discharge records to Waterfalls Medical Practice, PC form (indicate all that apply)

1. Physician Name
2. Physician Name
3. Physician Name
4. Physician Name
5. Hospital
6. Hospital
7. Other Facility

In addition, my protected Health information may be released or discussed with (indicate all that apply):

- Spouse
- Children
- Other

Doo NOT release to anyone.

Insurance Release

I authorize the submission of medical claims to my insurance company, and I am aware of my financial responsibility and agree to pay any balances that may be a result of the filing, for example deductible and or/coinsurance or ineligibility for coverage.

Patient Signature/Date

Patient representative/legal guardian signature. Relationship

Date signed by representative/legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name Date of Birth

Address

I have received a copy of Waterfalls Medical Practice, pc Notice of Privacy Practices which describes how my health information is used and shared. I understand that Waterfalls Medical Practice, PC has the right to change this notice at any time. I may obtain a copy from the practice website at:
http://www.waterfallsmedicalpractice.org.

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices:

Patient Signature/Date

Patient representative/legal guardian signature. Relationship

Date signed by representative/legal guardian