NEW PATIENT REGISTRATION FORM (please print)

Today's Date: _____ **Doctor:**_____

Patient's Name:_____**Maiden**_____
Last **First** **MI**

Date of Birth (DOB): _____ **Sex: M F**

Marital Status: Single Married Divorced Widowed

Mailing Address:_____
Street **City, State** **Zip Code**

Home Phone:_____**Cell phone:** _____

Work Phone:_____**E-mail Address:** _____

Occupation: _____**Employer:**_____

Employer Address:_____

Spouse Name: _____ **Spouse DOB:** _____

Day Phone: _____

Emergency Contact (if other than spouse): _____ **Phone:** _____

How did you hear about Woodlands Wellness & Cosmetic Center: (Check one)

- ❒ Friend: Name_____
- ❒ Doctor: Name_____
- ❒ Event: _____
- ❒ Website:_____
- ❒ Online:_____
- ❒ Social Media:_____
- ❒ Other:_____
- ❒ Woodlands Lifestyles & Homes Magazine
- ❒ Real Self

Signature_____ Date _____

PATIENT FINANCIAL AGREEMENT

Thank you for allowing our office the privilege of serving your medical needs. The Woodlands Wellness & Cosmetic Center is a place where the genuine care and welfare of our patients is our highest mission. That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.
   For your convenience, we accept cash, Master Card, Visa, Discover, American Express and CareCredit. ***We do apologize for any inconvenience as we do not accept checks.***
2. Balances older than 30 days will be subject to collection fees and/or interest charges unless other arrangements have been made. As a member of the Credit Bureau, unpaid balances are reported at our discretion.
3. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract**. Therefore you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
4. If any Pre-certifications are required by your insurance company for allergy testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office cannot be held responsible.
5. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing the Woodlands Wellness & Cosmetic Center to send your complete medical records to your insurance company once they are requested.

Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A photocopy of this document shall be considered as effective and valid as the original.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

Confirmation of Office Policy Procedures

Thank you for allowing our office the privilege of serving your medical and cosmetic needs.

Please initial that you have read and understand the policies of Woodlands Wellness and Cosmetic Center.

_____ I understand that if for any reason I do not cancel or reschedule an appointment at least 24 hours prior to the wellness appointment or 48 hours to the cosmetic appointment, I will be charged a $50.00 fee to my credit card on file.

_____ I understand that I am to remit my payment for services in full at the time services are rendered and that Woodlands Wellness and Cosmetic Center does not have a contract with any insurance company and that I am responsible if I would like to submit the paperwork to my insurance provider myself for reimbursement.

_____ I understand that Dr. Davis requires follow up visits for additional prescription refills (this could be 3, 6, or 9 months following the initial visit depending on the medication). I also understand that Dr. Davis will not provide additional refills if you have not come in for a follow up visit.

_____ I authorize Woodlands Wellness and Cosmetic Center to take pictures of me at any time before, during, and after treatments for purposes of documenting progress.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

No Show / No Cancellation policy Effective January 1, 2012

Due to the nature and availability of our practice it is important to us that we have a No show / No Cancellation policy in place. This also will give our guests on the waiting list an opportunity to be seen earlier if possible.

Therefore we require at least a 24 hour notice prior to your wellness appointment or 48 hour notice prior to your cosmetic appointment if you are unable to keep it as scheduled. If you do not call to cancel your appointment within that 24 hour wellness or 48 hour cosmetic window, there will be a $50 fee charged to your credit card at the end of that business day.

CREDIT CARD AUTHORIZATION:

Patient name: _____

Name on card: _____

CC #: _____

CC type: MasterCard VISA AMX Discover CareCredit

Exp date: _____ 3 digit code _____

Cardholder signature: _____ Date: _____

By signing, I understand and I have read the new No Show/ No Cancellation Policy for Woodlands Wellness and Cosmetic Center.
This policy will also help us expedite any orders, supplements or cosmetics you may need shipped directly to you from our office the same day the order is placed.

DISCONTINUE CREDIT CARD BILLING:

By declining or discontinuing my credit card authorization, I understand my account will still incur charges as set forth in the No show/ No cancellation policy. Also, as a new guest, with this discontinuation or without a valid credit card on file, I understand I am not guaranteed that my appointment time will be held without confirmation.

Date: _____ Signature: _____

NOTICE TO ALL MEDICARE, MEDICAID, CHAMPUS, WPS &/ OR TRICARE BENEFICIARIES

The Woodlands Wellness & Cosmetic Center does not participate in Medicare, Medicaid, Champus, WPS or TriCare programs and has chosen to opt out of Medicare. The Woodlands Wellness & Cosmetic Center has found that due to the pittance allowed by these government agencies, we are unable to meet overhead expenses. The Woodlands Wellness & Cosmetic Center is a Free Enterprise and would like to be able to extend quality medical care to you; however, due to the rules instituted by the government of the United States pertaining to these government agencies, the practice is unable to administer medical care to patients covered by them unless you read and sign the attached Waiver. We urge you to write your congressman if you have a problem with the rules instituted by these agencies.

WAIVER

I understand that The Woodlands Wellness & Cosmetic Center is not a Medicare, Medicaid, Champus, WPS or TriCare provider and has chosen to opt out of Medicare.

I accept full financial responsibility for any charges incurred.

Further, I understand that by signing this form, I waive my right to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services. Additionally, I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file to any other insurance policies.

☐ I do not have Medicare or Medicaid

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

HIPAA POLICY

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The term of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how we protect health information about you if it's used, disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review the notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent.

I authorize Woodlands Wellness and Cosmetic Center to release my medical records or insurance information as necessary to process my medial claims and coordinate or manage my health care.

Due to HIPPA, the following information must be updated **by each patient annually**.

Patient Signature: _____ Date: _____

Print Name: _____

HIPAA - ACKNOWLEDGEMENT OF REVIEWOF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers/Email of individuals who are authorized to receive my medical information:

1_____

2_____

3_____

4_____

(Circle Y or N)

Y N It is ok to send me an e-mail

Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

1. _____ OK to leave a message re: items such as lab results, vitamins, refills etc.
2. _____ Please do not leave specific message but a general message is OK.
3. _____ Do not leave any messages at all.

_____

Signature of Patient / Parent if minor

_____ _____

Printed Name of Patient Printed Name of Parent if minor

_____ _____

Date Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guideline. A copy of these guidelines is available upon request.