Wellness Resolutions, LLC

Registration Form

Today's Date:	Primary care doctor:	Doctor address:	
Patient Last name, First, Middle:		Birthdate:	Age:	Gender: M F
Street address:	City and state:	Zip code:	
Home phone:	Cell phone:	E-mail:	
Occupation:	Employer:		
Preferred phone contact method: □Home □Cell	Is it ok to e-mail and or text you about appointments? Yes No	Would you like to received e-mails about special programs? Yes No	
How did you hear about us? □Google □Bing □Facebook □Friend/Family/Doctor (name):			

Insurance Information		
Insurance type: □ Blue Cross □United □Tufts □Medicare □Aetna □Cigna □Neighborhood □Self pay/Cash		
Insurance plan name:	Member ID on card:	
Subscriber name:	Subscriber birthdate:	Relationship to insured: □ Self □Spouse □Child □Other
Subscriber address: □ Check here if same as PT	City and state:	Zip code:
Secondary Insurance Information (if applicable)		
Insurance type: □ Blue Cross □United □Tufts □Medicare □Aetna □Cigna □Neighborhood		
Insurance plan name:	Member ID on card:	
Subscriber name:	Subscriber birthdate:	Relationship to insured: □ Self □Spouse □Child □Other
Subscriber address: □ Check here if same as PT	City and State:	Zip Code:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Wellness Resolutions, LLC. I also authorize Wellness Resolutions, LLC or my insurance company to release any information required to process my claims. I understand that I am legally and financially responsible for any balance not paid by my insurance company.

Do you give consent to sign this document electronically? Please INITIAL in the YES or NO box to consent to your electronic signature. YES I consent to sign electronically: ☐ NO I do not consent to sign electronically: ☐

Type name here to electronically sign this document:	Today's Date:

<u>**24 Hour Appointment Cancellation and Rescheduling Policy**</u>

Wellness Resolutions, LLC of Rhode Island has a 24 hour cancellation and rescheduling policy. **If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $50.** This policy is in place out of respect for our staff and our clients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. To be a patient in this practice you must provide a credit card number on or before your first appointment. Your card will automatically be charged if you fail to cancel or reschedule an appointment without 24 hours' notice.

How would you like us to remind you about your appointments?

Text Message at phone number:______________________________

OR

Phone call at phone number:________________________________

OR

E-mail:____

By signing below, you acknowledge that you have read and understand the cancellation policy and that you agree to pay any and all charges on your credit card due to last minute cancelations. Thank you for your understanding and cooperation.

Do you give consent to sign this document electronically? Please INITIAL in the YES or NO box to consent to your electronic signature. Tying your name on the line below constitutes an electronic signature.

YES I consent to sign electronically: ☐ NO I do not consent to sign electronically: ☐

____

Signature

____

Date

Wellness Resolutions, LLC

ACKNOWLEDGMENT OF RECEIPT OF OUR

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: Sept. 9, 2019

By signing below, I acknowledge that I have been provided with a copy of the Wellness Resolutions, LLC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Wellness Resolutions, LLC and how I may obtain access to and control this information.

Do you give consent to sign this document electronically? Please INITIAL in the YES or NO box to consent to your electronic signature. Tying your name on the line below constitutes an electronic signature.

YES I consent to sign electronically: ☐ NO I do not consent to sign electronically: ☐

Signature of Patient or Personal Representative:

____

Date

____

Description of Personal Representative's Authority: Check One Box Below

Patient **Guardian** **Personal Representative**

Wellness Resolutions, LLC Notice of Privacy Practices
Effective Date: Sept. 9, 2019

This notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. We understand that health information about you is personal. We create a record of the care and services you receive at Wellness Resolutions and are committed to protecting that information. We are required by law to make sure that information that identifies you is kept private and to give you this notice of our privacy practices and the follow the terms of the notice that are currently in effect.

Our Uses and Disclosures

We may use your protected health information (PHI) to:

- **Treat you:** We can use your PHI to treat you. We may share your PHI with other professionals in our practice including but not limited to dietitians, office staff, billing staff, etc. We may also share your PHI with your primary care doctor, a doctor that referred you to our practice or other members of your health care team.
- **Run our organization:** We can use and share your PHI to run our practice, improve and evaluate the care you received from us and or conduct business planning activities for our practice. There are some services that are provided through our business associates. We may also contact you when necessary.
- **Bill for your services:** We may use and disclose your PHI, an insurance company, or a third party in order to bill and collect payment for the services you receive from us. This may include verifying your health benefits or providing information to obtain prior approval.
- **Help with public health and safety issues**
- **Comply with the law**
- **Respond to organ and tissue donation requests**
- **Work with a medical examiner or funeral director**
- **Address workers' compensation, law enforcement, and other government requests**
- **Respond to lawsuits and legal actions**

Your Rights

You have the right to:

- **Get a copy of your paper or electronic medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Correct your paper or electronic medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. We may say no to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say yes to all reasonable requests.
- **Ask us to limit the information we share:** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say no if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.
- **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures made. This accounting will not include routine disclosures for treatment, payment, or health care operations purposes. In order to obtain an accounting of disclosures, you must submit your request in writing.

- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **Get a copy of this privacy notice**

Minors and Persons with Guardians

Minors and certain disabled adults are entitled to the privacy protection for their health information. Because by law, they cannot make health care decisions for themselves, however a parent or guardian can make medical decisions on their behalf. Therefore, parents or guardians can authorize the use and release of PHI and also hold all rights listed in this notice. Under certain situations defined by law, minors can make independent healthcare decisions without parent or guardian knowledge or consent. In those situations, the minor may hold all rights listed in this notice. If the minor chooses to inform the parent or guardian, then all privacy rights regarding PHI may transfer to the parent or guardian. There are also certain situations where access, use or release of a minor's PHI may occur without the consent of the parent or guardian, i.e. when the health or safety of the minor is in danger and PHI is necessary to protect the minor.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You may also file a complaint with our office Wellness Resolutions, LLC, Attn: Security Official, 1920 Mineral Spring Ave, #10, North Providence, RI 02904.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Additional questions about this notice should be directed to our Security Officer (401) 305-6602

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we have created or maintained in the past, and for any we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.