

New Patient Enrollment

Patient Information:

Patient Legal Name: _____ PreferredName: _____

Mailing Address: _____
City: _____ State: _____ Zip: _____

Street Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ CellularPhone: _____

Date of Birth: _____

Sex: F M Marital Status: Married Single Other _____

Employer/Vocation: _____

Financially Responsible Party Information: (If different from patient)

Name: _____ Relationship to Patient: Spouse Other _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance Verification (Please present insurance card and photo ID at registration)

1) Primary Insurance Company: _____

Relationship of patient to insured: (circle one) Self Spouse Child Other _____

Policy Holder: _____ Date of Birth: _____

Employed by: _____

Policy ID# _____ Group ID#: _____

Insurance Policies

Payment is due at time of service. Please present your insurance cards to the registration desk. If insurance information is not provided, you will default to a self-pay status. Payment, to include co-pays is required prior to a visit. There will be no exceptions to this policy. You will be asked to reschedule your visit if you do not provide the required information and payment/copayment at the time of

service. Please complete the Insurance Verification form provided. You will need to contact your insurance company at the mental health phone number they provide on your insurance card. You may use the invoice we provide to you to bill your insurance company if you are self-pay. Sara Weelborg ARNP accepts cash, debit and credit cards, and personal checks. At this time, Sara Weelborg ARNP is contracted with Regence BlueShield and Premera Blue Cross of Washington, Tricare (United Behavioral Military and Veterans), First Choice, Group Health Options PPO, United Healthcare, Medicare, Cigna, and Aetna. Commonly there are several types of health plans under these carriers and it is strongly recommended that the patient contact their plan prior to the visit to inquire about coverage.

My signature below indicates that I hereby assume all financial responsibility for services rendered by Sara Weelborg, ARNP. Sara Weelborg, ARNP does not negotiate claims with your insurance carrier. Reduction or rejection of the claim by your insurance carrier does not relieve you of the financial obligation you have incurred for services rendered. Sara Weelborg will accept the contract rate for the insurance plans she is contracted with and will not balance bill. It is your responsibility to determine whether your provider is in your network and to be aware of your current mental health insurance coverage. It is your responsibility to obtain authorization when required by your insurance company.

As a new patient, I agree to pay for services at the time of service. Should my insurance be billed, I understand that I am responsible for the copayment at the time services are rendered. Sara Weelborg, ARNP reserves the right to collect deductibles and coinsurance up-front if the account has been delinquent.

I agree to notify Sara Weelborg, ARNP when I move or change insurance carriers. I understand that I will be responsible for payment of all charges and will be expected to pay for all costs incurred for collections including court costs, attorney fees and collection agency fees incurred.

I authorize Sara Weelborg, ARNP to provide my designated insurance carrier all required information concerning my health information for payment purposes. I authorize benefits for insurance claims to be made directly to Sara Weelborg, ARNP.

I understand that certain services to be rendered in the practice may not be covered by my insurance carrier. I am financially responsible to Sara Weelborg ARNP for all charges for services not covered by my insurance carrier.

I attest that I have read and understand the above. Questions regarding this policy have been answered to my satisfaction.

Patient Signature: _____ **Relationship if not patient:** _____

Assignment of Benefits/Medical Release/Consent for Treatment

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I hereby consent to receive medical treatment, x-ray, or laboratory services, which the provider may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due me to be paid directly to Sara Weelborg, ARNP. This agreement will remain in effect until I choose to revoke it in writing.

Patient Signature: _____ **Relationship if not patient:** _____

**Protected Health Information (PHI) Release
For Family Member(s) and Healthcare Team Members**

I, _____ give Sara Weelborg, ARNP, my permission to have my protected health information (PHI) released to the following:

List individuals below (examples- family members, primary care providers, counselors)

_____, _____
Name Relationship

_____, _____
Name Relationship

I understand that by signing this agreement, I am giving my permission for the above listed people to receive and discuss my protected health information. I also understand that this release is valid until revoked in writing.

I authorize messages to be left at my contact numbers. Sara Weelborg ARNP will make every effort to minimize sensitive information left on answering services: (circle one) YES NO

I authorize an appointment reminder to be sent to my e-mail address listed here: YES NO

e-mail address: _____

***E-mail is used for appointment reminders only. E-mail and phone texting is not guaranteed to be private. Secure messaging through the health record is encouraged and will be discussed at appointment.**

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

What are your main health concerns?

Your Past Medical History (Please circle if yes)

Alcoholism	Yes	High Blood Pressure	Yes
Anemia	Yes	High Cholesterol	Yes
Anesthetic complications	Yes	Mental Illness	Yes
Anxiety	Yes	Osteoporosis	Yes
Asthma	Yes	Seizures	Yes
Birth Defects	Yes	Severe Allergies	Yes
Blood Clots	Yes	Stroke	Yes
Blood Transfusions	Yes	Suicide Attempt	Yes
Breast Cancer	Yes	Bowel Disease	Yes
Cervical Cancer	Yes	Heart Disease	Yes
Colon/Rectal Cancer	Yes	Kidney/Bladder Disease	Yes
Crippling arthritis	Yes	Lung Disease	Yes
Depression	Yes	Liver Disease	Yes
Diabetes	Yes	STD	Yes

RESPIRATORY:

Cough	Yes	Coughed up blood	Yes
Asthma	Yes	Do you snore?	Yes

CARDIAC:

Chest Pain	Yes	Shortness of breath	Yes
Swelling in your legs	Yes		

GASTROINTESTINAL:

Abdominal pain	Yes	Nausea or vomiting	Yes
Diarrhea	Yes	Heartburn	Yes
Constipation	Yes		

GENITOURINARY:

Blood in urine	Yes	Bladder problems	Yes
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INTEGUMENTARY:

Changes in warts or moles	Yes	Skin problems	Yes
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NEUROLOGICAL/PSYCH:

Frequent headaches	Yes	Recent visual changes	Yes
Weakness	Yes	Dizziness	Yes
Memory problems	Yes		

MUSCULOSKELETAL:

Joint problems	Yes	Swelling in legs or feet	Yes
Unusual pain in hands or feet	Yes	Stiffness in joints	Yes

HEMATOLOGICAL/LYMPH:

Fatigue	Yes	Easy bruising	Yes
Lumps under arms	Yes	Frequent infections	Yes

ALLERGIC/IMMUNOLOGIC:

Recurrent sinus infections	Yes	Seasonal allergies	Yes
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ENDOCRINE:

Thyroid problems	Yes		
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FEMALE:

Are you pregnant or is there a possibility that you might be pregnant? _____

PSYCHIATRIC HISTORY:

Have you ever been treated by a mental health professional in the past and if so, when?

Have you ever taken psychotropic medications? (antidepressants, anxiety medications, etc.) Yes No

If yes to above, please write a few brief comments about your experience with past psychotropic medications (such as name, dose, effect, side effects, etc.) _____

Have you ever been hospitalized overnight for observation or psychiatric treatment? Yes No

Have you ever attempted suicide or intentionally harmed yourself? Yes No

Other

Please comment on the reason(s) you are coming to see me for services and include any additional information you feel would be good for me to know about you. _____

I have reviewed Sara Weelborg's **Notice of Privacy Practices**. I understand there is a copy posted on the practice's website as well as available at the office should I wish to revisit it. I agree to direct any questions or concerns about this Notice to Sara Weelborg, ARNP.

Signed: _____

Date: _____