CLINTON FAMILY CARE

DAVID B. WHEAT M.D.
309A MORRISON DR.
CLINTON, MS 39056

REGISTRATION SHEET

TODAY'S DATE : _____

PATIENT INFORMATION:****DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER: _____

NAME LAST: _____ FIRST: _____ Middle Name _____

ADDRESS: STREET/APT: _____

_____ CITY/ STATE /**ZIP**: _____

_____ HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

_____ PREFERRED PHARMACY: _____

_____ SEX: (CIRCLE) M F MARITAL STATUS: S M W D AGE: _____

(Now Required by Feds) RACE: ☐ White ☐ Amer Indian/Alaska Native ☐ Black ☐ Asian ☐ Native Hawaiian/ Pacific Island

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ unknown

Language: ☐ English ☐ other _____

EMPLOYER: _____

ADDRESS: _____

INSURANCE COMPANY: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S ADDRESS: _____

POLICY HOLDER'S BIRTH DATE: _____

POLICY HOLDER'S SSN: _____

POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S ID NUMBER: _____

POLICY HOLDER'S GROUP #: _____

EFFECTIVE DATE: _____

Responsible Party (if different than patient): _____

ADDRESS: _____

_____ CITY/STATE/ZIP/PHONE # : _____

IMPORTANT:**

I confirm that a copy of Clinton Family Care's Privacy Policies is available for me to read if I so choose to read it.

IN CASE OF EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

CHOOSE ONE OF THE FOLLOWING OPTIONS:

☐ **I authorize Clinton Family Care physician or personnel to discuss my treatment, payment, or healthcare information with _____ (name of person we can talk with), who is my spouse, parent, child, friend, companion, grandparent, other.(please circle one or add) _____ Phone # : _____**

OR ☐ **I do not give permission for the discussion of my medical care with anyone other than myself.**

POLICIES AND CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, assignment of benefits and office policies.

Authorization to Release: I hereby authorize Clinton Family Care and any physician providing treatment to me, to release or disclose to insurance companies and/or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Authorization to Pay Insurance Benefits: I hereby assign payment directly to Clinton Family Care of all insurance and similar benefits otherwise payable to me by virtue of medical treatment provided by CFC, but not to exceed CFC's regular charges for medical treatment. I understand I am financially responsible for charges not covered by insurance, and I hereby agree to be responsible for all charges incurred, regardless of the status of medical insurances or similar benefits.

Consent for Treatment: The undersigned patient or patient's guardian/representative authorize(s) the physician to furnish medical and surgical treatment by those means considered necessary and proper in the treatment of the patient identified below while a patient at CFC. This treatment may require diagnostic procedures including but not limited to lab tests, drawing blood for those tests, x-rays, electrocardiograms, etc. I am aware that the practice of medicine is not an exact science and that the physician relies upon the information provided by the patient or authorized representative to be accurate and correct so that he/she may treat the patient as needed. I acknowledge that no guarantees have been made to me as a result of said medical treatment.
I understand that if I have had an outstanding balance for more than three months, I may not be seen until that financial obligation is cleared. If I have given you an insufficient funds check for payment, I may be required to pay for future obligations by cash only.

Consent for Retirement of X-ray Films and Graphic Data: The undersigned authorizes the office to retire x-ray films and any other graphic data which may be generated seven years after they are generated if the written and signed findings of a radiologist or other professional who has interpreted the x-ray or graphic data is maintained in the medical record.

Valuables: The undersigned hereby releases CFC and/or its staff from any responsibility due to loss or damage of any valuables that the patient or representatives accompanying them may keep in his/her/their possession while on the premises of CFC. CFC is not responsible for injuries or mishaps sustained by children left to play outside or left in vehicles. We are not responsible for any vehicular accidents or damages to property in our parking lots.

Payment Terms / Late Fee: I understand that payment in full is due at the time of service for all services provided, and I agree to pay all charges for the patient named below. **All co-pays are due the day of service. If I have to be billed for my co-pay, a twenty ($**20) **dollar fee will be assessed in addition to the co-pay. If I have not met my deductible, payment in full will be due at time of service.** If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance. We file most insurances as a courtesy to our patients; however, your insurance coverage is a contract between **YOU** and **your insurance carrier**. If they do not respond in a timely manner (30-45 days), I will be responsible for the charges. I will be responsible for any non-covered services, or services that my insurance carrier deems not medically necessary, that may be denied by my carrier. We do not perform any services that we do not feel are necessary. I will verify that CFC participates with my insurance carrier and that CFC has a copy of my current insurance card. I am responsible for updating CFC on any changes in insurance, change of address, or personal information. On any balance remaining more than thirty(30) days after the date of service or after insurance responds, I will pay a late fee of $10; after 60 days a late fee of $15 and after 90 days a late fee of $25. If my account is outstanding for three statement periods, I understand that CFC will stop sending statements and turn the account over to collections. At this time, there will be a 35% assessment added to my account for processing.

Any insufficient funds checks will **NOT** be sent to the bank again. There will be a $40 fee for each check returned for insufficient funds. I will have fifteen (15) days from the date of the notice to take care of the insufficient check. If no response is received from me after fifteen days, the check will be turned over to the district attorney's office for processing pursuant to the "Mississippi Bad Check Law" (section 97-19-55 of the Mississippi Code).

Office personnel will be available to answer any questions you have regarding this form.

I certify that I have read and understand this form in full.

Print Patient Name	Signature of Patient / Guardian (if minor)	Date

PRINT NAME HERE_____ **DATE OF BIRTH** _____

INFORMED CONSENT TO ARBITRATION **PAGE 1**

XX_____ **(patient)** employs Dr. David B. Wheat
(**PRINT** Patient Name here)
to act as his/her personal physician in the treatment and management of medical care and services. For, and in partial consideration of, the rendition of any and all present and future medical care and services, Patient agrees that, in the event of any dispute or controversy arising out of claims based on negligence or medical malpractice between Patient or Patient's heirs-at-law or personal representative and the Physician, such dispute or controversy shall be settled by arbitration administered by an independent medical arbitration board in accordance with its Commercial Arbitration Rules; judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

All parties agree that this agreement shall be governed by the Federal Arbitration Act and that the arbitration shall be held in the city where the medical care and services were provided. Both agree to be bound by the arbitrator's decision, including any fee claims involved in the disputed treatment. The award of the arbitrator shall be accompanied by a reasoned opinion, and each party shall bear its own costs and expenses as well as an equal share of the administrative fees of arbitration. This agreement shall be effective as of the date of first medical services rendered to the patient by the Physician. In the event the patient is financially unable to bear the cost of arbitration, Physician or his agent will bear the cost of the arbitration. The patient agrees to not participate in any mass torts against this Physician.

This agreement may be rescinded by either party within (15) fifteen days of signature by written notice. However, any dispute as to medical malpractice arising out of services rendered prior to the date of such written notice shall be subject to the terms of this arbitration agreement. Written notice of such recision may be given by a guardian or conservator of the Patient if Patient is a minor or incapacitated. If any portion of this agreement is found unenforceable, that portion shall be stricken and the remainder of this agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services were rendered.

BY SIGNING THIS CONTRACT, PATIENT ACKNOWLEDGES THAT HE OR SHE HAS AGREED TO HAVE ANY DISPUTE OR CLAIM FOR DAMAGES RELATING TO ANY MEDICAL ADVICE, TREATMENT**, OR SERVICES PROVIDED BY PHYSICIAN DECIDED BY NEUTRAL ARBITRATION RATHER THAN IN A COURT OF LAW AND FURTHER AGREES THAT SUCH AGREEMENT WAIVES THE PATIENT'S RIGHT TO A JURY OR COURT TRIAL. PATIENT ALSO ACKNOWLEDGES THAT THIS WAIVER IS SIGNED WITHOUT DURESS.**

Signed, this the _____day of _____, 2015.

XX ***ADULT PATIENT SIGN HERE***_____ _____
(Physician)

If a **PARENT OR GUARDIAN** has signed on behalf of their minor child or ward, such parent or guardian attests that he or she has full legal authority to execute this arbitration agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Physician from any claim, demand, or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

XX_____ DATE OF BIRTH: _____
(PARENT OR GUARDIAN SIGN HERE IF PATIENT IS A MINOR)

SUMMARY OF ARBITRATION AGREEMENT **PAGE 3**

IF YOU HAVE ANY QUESTIONS, PLEASE ASK EITHER THE FRONT OFFICE, THE NURSES, OR THE PHYSICIAN.

PATIENT, PLEASE INITIAL IN EACH BOX BY THE X:

	EXPLANATION OF PROVISION	PATIENT PLEASE INITIAL IN BOX BY 'X'
1.	Patient is agreeing to arbitrate any dispute or controversy, including one arising from medical malpractice. Patient is agreeing **not to sue** the Physician **in a court of law.**	**X**
2.	Patient is **waiving his or her right to a jury trial.**	**X**
3.	**Arbitration will be performed by a neutral medical arbitration board.** This will be a national association of trained, neutral arbitrators. The arbitrators do not work for the Physician or the Patient. **The Physician and the Patient will split the cost, and each side will pay for their own attorneys if needed. If patient is unable to do this, physician or his agent will help defray costs of arbitrators but not of attorneys.**	**X**
4.	**This agreement is retroactive** to the date the Physician first provided treatment to Patient.	**X**
5.	Patient may **rescind or cancel this agreement within (15) fifteen days by written notice**, but must still arbitrate any claim arising before the agreement is rescinded.	**X**
6.	If the Patient does not agree to arbitrate, or if they rescind or cancel the arbitration agreement, Physician **has the option to refer them to another doctor** or group who can provide the medical care and treatment they need.	**X**
7.	If a lawsuit is filed, it must be in the county where the medical care and services were rendered.	**X**
8.	Patient acknowledges that if they still have questions, they should **consult an attorney** before signing. Patient acknowledges that they are signing this agreement voluntarily and without duress.	**X**

I hereby confirm that I have explained the arbitration agreement to the patient, and the patient has affirmed his or her understanding of that agreement by initialing or signing beside each of the foregoing provisions.

XX_____(patient please sign here)

_____(physician sign here)

_____

(Date)