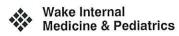


Wake Internal Medicine Consultants, Inc.









PATIENT REGISTRATION		
		Chart:
		Doctor:
Patient Information		Date:
Name:		
Address:		Apartment No.:
City:	State:	Zip Code:
Telephone (Primary):		
Cell Phone for receiving text messages:	Email:	
Birthdate:	_Sex: M F	Marital Status: M S Other
Social Security Number:E	mployer:	
Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Declines Language: ☐ English ☐ Other Primary Physician (if seeing GI or GYN doctor): How did you hear about us? ☐ Physician Referral ☐ Family/Frien ☐ Insurance Carrier ☐ Direct Mailer ☐ Google ☐ W	d □ Other	
Person to contact in case of emergency?	N. G	
Emergency Telephone:		
Preferred Pharmacy and Location:		No cast or right
Preferred Method of Contact: ☐ primary phone ☐ mail	□ email	(patient portal-secure messaging)
Responsible Party		
Party responsible for payment: Self Spouse Parent Othe	r	
Name (if other than Self):		
Address:		-11 5 1 5 5 M
City:	State:	Zip Code:
Employer:		
Insured Party (Primary Card Holder)		
Name:		
SS#DOI	3:	" milk of

Initials	By providing us your email address you are consenting to the use of secure messaging and our patient portal.			
	CREDIT POLICY			
Initials	Wake Internal Medicine will be happy to file claims to your insurance company as a courtesy to you. However, seeing that your account is paid is <u>your</u> responsibility. We do expect timely settlement of your account, and payment at the time of service is expected. Any delinquent accounts may be reported to the Credit Bureau.			
ASSIGNMENT AND RELEASE				
Initials	I, the undersigned, understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Wake Internal Medicine Consultants, Inc. to release all information necessary to facilitate the processing of all claims related to my care. I authorize use of this signature on all my insurance submissions.			
MEDICARE PATIENTS ONLY				
Initials	I acknowledge that I have been informed of Wake Internal Medicine Consultants non-participation with the Medicare Program and acknowledge that benefits will be paid to me unless other- wise prohibited by Medicare regulations. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "OTHER HEALTH INSURANCE" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I acknowledge my responsibility to pay the amount determined by Medicare to be my responsibility to Wake Internal Medicine Consultants, Inc. in full on the date the service is rendered or as soon there after as can be arranged by mutual consent.			
	PRIVACY POLICY			
Initials	I hereby acknowledge receipt, before any medical services were provided, of a "Notice of Privacy Practices of Wake Internal Medicine Consultants, Inc." for protected health information. I acknowledge that I have been given the opportunity to ask any questions that I may have regarding such policy. I understand that WIMC may use or disclose personal health information relating to me for purposes of treatment, payment, and health operations as disclosed in the notice.			
NO SHOW/LATE CANCELLATION POLICY				
Initials	I acknowledge that Wake Internal Medicine reserves the right to charge a fee for missed appointments or procedures. A missed appointment is defined as failure to show for your scheduled appointment or a cancellation/reschedule within less than 24 hours of the appointment time slot (3 business days for procedures).			
	Patient Signature:			
	Print Name:			
	Date:			