WELLSPAN
PATIENT
INFORMATION

WellSpan® Medical Group

New Patient Registration Information

WellSpan®
Medical Group

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

WELLSPAN FINANCIAL POLICY

Thank you for choosing WellSpan Health for your healthcare needs. Our goal is to provide our community with the highest quality of care in the most cost-effective manner. The following information outlines your financial responsibilities related to payment for services received.

General Information

Your copay, deductible, coinsurance or, under certain circumstances, payment in full is due at the time of service. We accept cash, check, VISA, MasterCard, Discover and American Express. A $25 fee is charged for checks returned for insufficient funds.

Health Insurance

WellSpan providers participate with a wide variety of insurance plans. We suggest that all patients review their health insurance coverage prior to receiving services or treatment. It is the responsibility of the patient to notify us of any changes to their insurance coverage. Your insurance policy is a contract between you and your insurance company.

Although our staff is very knowledgeable about the various insurance plans with which we participate, you are in the best position to understand the detailed terms of your specific plan. We will submit claims to your primary and secondary insurance companies, whether we participate or not. The patient/guarantor will be responsible for any remaining balance. It is your responsibility to obtain and track referrals for your visits.

Pennsylvania law allows patients to "opt out" of their insurance for services they do not want submitted to their carrier. Patients choosing to "opt out" are not eligible for any self-pay discounts and payment is due at the time services are rendered.

Self-Pay Patients

Patients without health insurance are expected to pay in full at time of service. As a courtesy, we offer a 20% discount on eligible services.

Worker's Compensation

It is the patient's responsibility to inform us of work-related injuries/illnesses and to provide us with the necessary Worker's Compensation policy information. WellSpan will bill your employer's carrier, following all procedures as required by Pennsylvania's Worker's Compensation laws.

Automobile Claims

It is the patient's responsibility to inform us if their visit is related to an automobile accident and to provide us with their Automobile Insurance policy/claim information as well as their Health Insurance information. We will submit the claim to the automobile insurance carrier and, if benefits are exhausted or services are denied, we will submit the claim to your health insurance carrier.

WFPX0001

WELLSPAN®
Medical Group

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

WELLSPAN FINANCIAL POLICY

Other Liability Cases

It's the patient's responsibility to inform us if their visit is related to a motorcycle accident or other third party liability (such as a slip and fall injury at a place of business) and to provide us with all necessary information needed to submit a claim. WellSpan will submit the initial claim for services as a one-time courtesy to the patient. The patient/guarantor remains responsible for any and all balances due to this injury.

Payment Arrangements/Financial Assistance

If you are unable to pay your bill in full, please contact our Customer Service Department at 717- 851-5005. WellSpan Health provides patients the opportunity to enter into payment plans for patient balances. If eligibility criteria are met, WellSpan Financial Assistance may be available.

We reserve the right to consider delinquent patient accounts for external collection efforts in accordance with state and federal regulations.

I have read, understand and agree to this Financial Policy:

_____	_____	_____	_____
Patient Signature	Printed Name	Date	Time
_____	_____	_____	_____
Legal Guardian/Guarantor Signature	Printed Name	Date	Time
_____			
Relationship to Patient			
_____	_____	_____	_____
Witness Signature	Printed Name	Date	Time

WELLSPAN® Medical Group

If label not available, please fill in below.
NAME: ______________________
DOB: ______________________
MRN: ______________________

PATIENT COMMUNICATION/PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Date of Birth	Effective Date (mm/dd/yyyy)
Primary Phone	Other Phone	

My preferred method of communication (check only one):
☐ Primary phone ☐ MyWellSpan ☐ Other phone ☐ Other: ______________________
(If WellSpan is unable to reach you via the preferred method, we will use other available methods.)

The following information may be left on the phone:
☐ Detailed Message (including any information related to treatment or payment).
☐ Message requesting a return call

I give permission for WellSpan to VERBALLY share the information I have checked with the family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of my health care.

☐ **NONE**

PARENTS/LEGAL GUARDIANS PLEASE INCLUDE YOUR NAME ON THE FORM

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Check all that apply:
☐ Scheduling/Appointment information
☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
☐ Lab/test results ☐ HIV results ☐ Billing and payment information
☐ Other (describe): ______________________

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Check all that apply:
☐ Scheduling/Appointment information
☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
☐ Lab/test results ☐ HIV results ☐ Billing and payment information
☐ Other (describe): ______________________

Name: ______________________ **Relationship:** ______________ **Phone:** ______________

Check all that apply:
☐ Scheduling/Appointment information
☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
☐ Lab/test results ☐ HIV results ☐ Billing and payment information
☐ Other (describe): ______________________

WPTC0001

WELLSPAN®
Medical Group

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

PATIENT COMMUNICATION/PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION (PHI)

Name: _____ **Relationship:** _____ **Phone:** _____

Check all that apply:

☐ Scheduling/Appointment information

☐ Medical information, including my symptoms, diagnosis, medications and treatment plan

☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan

☐ Lab/test results ☐ HIV results ☐ Billing and payment information

☐ Other (describe): _____

Schools

The following is to be completed for patients that are of school age (under 18):

As parent/legal guardian of this minor child, I agree to have WellSpan Health provider(s) disclose proof of immunizations to the school noted below.

School Name: _____

School District: _____

I understand that in certain situations WellSpan may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where WellSpan has already made disclosures based upon this request. I understand this permission remains in effect until I complete and submit a revised form.

This form does not authorize releasing copies of my records with the exception of immunization records to schools.

Indicate relationship to patient: ☐ Patient ☐ Patient Representative Relationship: _____

Signature: _____ Date: _____ Time: _____

Print Name (if other than patient): _____

WellSpan® Medical Group

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name: _____ DOB _____ Age: _____ Date: _____

Address: _____ Contact #: _____

Preferred Language: _____ Occupation: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SEX: ☐ M ☐ F

Please list any Hearing, Vision or Reading issues: _____

_____

Do you have an Advanced Directive? ☐Yes ☐No Would like to make or revise your Advanced Directive? ☐Yes ☐No

Do you have regular dental checkups? ☐Yes ☐No Do you have Dental Insurance? ☐Yes ☐No

Please bring all your prescription medicines and over-the-counter vitamins and supplements to your appointment, OR list all prescription and over the counter medications, supplements and vitamins you take, including the dose or strength.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to latex? ☐Yes ☐No List allergies: _____

PAST MEDICAL HISTORY – Do you have now or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Eczema	☐	☐	Mental health disorder	☐	☐
Allergic rhinitis	☐	☐	Emphysema	☐	☐	Nerve/muscle disease	☐	☐
Allergies	☐	☐	Failure to thrive	☐	☐	Obesity	☐	☐
Anemia	☐	☐	GERD/Acid reflux	☐	☐	Osteoporosis	☐	☐
Anxiety	☐	☐	Glaucoma	☐	☐	Pneumonia	☐	☐
Arthritis	☐	☐	Headache	☐	☐	Scoliosis	☐	☐
Asthma	☐	☐	Hearing loss	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Heart attack	☐	☐	Sickle cell anemia	☐	☐
Cataracts	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Heart Failure (CHF)	☐	☐	Hepatitis	☐	☐	Thyroid disease	☐	☐
Clotting disorder	☐	☐	HIV/AIDS	☐	☐	Tuberculosis	☐	☐
COPD	☐	☐	Hypertension	☐	☐	Ulcers (GI)	☐	☐
Depression	☐	☐	Inflammatory bowel dis.	☐	☐	UTI	☐	☐
Diabetes mellitus	☐	☐	Jaundice	☐	☐	Varicella	☐	☐
Drug abuse	☐	☐	Kidney disease	☐	☐	Vision problems	☐	☐
Eating disorder	☐	☐	Meningitis	☐	☐	Other		

WPCF0001

WellSpan® Medical Group

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

FAMILY HISTORY – Do you have a family history of?

	Yes	No	Relationship		Yes	No	Relationship
Alcohol abuse	☐	☐		Hyperlipidemia	☐	☐	
Arthritis	☐	☐		Hypertension	☐	☐	
Asthma	☐	☐		Kidney disease	☐	☐	
Cancer	☐	☐		Lupus	☐	☐	
Crohn's disease	☐	☐		Mental disease	☐	☐	
Cirrhosis	☐	☐		Miscarriage	☐	☐	
COPD	☐	☐		Multiple sclerosis	☐	☐	
Depression	☐	☐		Rheum arthritis	☐	☐	
Diabetes	☐	☐		Osteoarthritis	☐	☐	
Drug abuse	☐	☐		Stroke	☐	☐	
Early Death	☐	☐		Thyroid disease	☐	☐	
Fragility/Fractures	☐	☐		Ulcerative colitis	☐	☐	
Gout	☐	☐		Vision problems	☐	☐	
Hearing loss	☐	☐		No pertinent Fm. Hx.	☐	☐	
Heart Disease	☐	☐		Family Hx. unknown	☐	☐	

YOUR PERSONAL HABITS – Do you?

	Yes	No
Exercise regularly	☐	☐
Smoke or use tobacco	☐	☐
How much		
For how many years		
Exposed to second hand smoke	☐	☐
Vape	☐	☐
Drink alcohol	☐	☐
How much		
Have you ever had a blackout	☐	☐
Would you like to cut down	☐	☐

During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?		
☐ Not at all	☐ Slightly	☐ Moderately
☐ Quite a bit	☐ Extremely	
During the past 4 weeks, was someone available to help you if you needed and wanted help?		
☐ Yes	☐ No	☐ N/A

PAST SURGICAL HISTORY – Please list any operations you have had:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____ _____

Patient Signature | Patient Printed Name | Date | Time

_____ _____ _____ _____

Reviewed by Provider (Signature) | Provider Printed Name | Date | Time

Form #10745 Rev. (06/18)

WPCF0001

WellSpan® Medical Group

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PATIENT HEALTH HISTORY – REVIEW OF SYSTEMS FORM

GENERAL HEALTH PROBLEMS

CONSTITUTIONAL	Yes	No
Activity/Appetite change	☐	☐
Chills	☐	☐
Sweating	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected wt. change	☐	☐
EARS, NOSE THROAT		
Congestion	☐	☐
Dental Problems	☐	☐
Drooling	☐	☐
Ear discharge/pain	☐	☐
Facial swelling	☐	☐
Hearing loss	☐	☐
Mouth sores	☐	☐
Nosebleeds	☐	☐
Post nasal drip	☐	☐
Rhinorrhea	☐	☐
Sinus pain/pressure	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Ringing in the ears	☐	☐
Trouble swallowing	☐	☐
Voice changes	☐	☐
EYES		
Eye discharge/itching	☐	☐
Eye pain/redness	☐	☐
Photophobia	☐	☐
Visual disturbance	☐	☐
RESPIRATORY		
Apnea	☐	☐
Chest tightness	☐	☐
Choking/cough	☐	☐
Shortness of breath	☐	☐
Stridor	☐	☐
Wheezing	☐	☐
CARDIOVASCULAR		
Chest pain	☐	☐
Leg swelling	☐	☐
Palpitations	☐	☐

GASTROINTESTINAL	Yes	No
Abd distention/pain	☐	☐
Anal bleeding	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea/vomiting	☐	☐
Rectal pain	☐	☐
ENDOCRINE		
Intolerance to heat/cold	☐	☐
Excessive urination	☐	☐
Excessive thirst	☐	☐
Excessive hunger	☐	☐
GENITOURINARY		
Difficulty urinating	☐	☐
Painful urination	☐	☐
Incontinent at night	☐	☐
Flank pain (side pain)	☐	☐
Frequency	☐	☐
Genital sores	☐	☐
Blood in urine	☐	☐
Pelvic pain	☐	☐
Urgency	☐	☐
Decreased urination	☐	☐
GENITOURINARY - FEMALE		
Menstrual problems	☐	☐
Vaginal bleeding	☐	☐
Vaginal discharge	☐	☐
Vaginal pain	☐	☐
GENITOURINARY - MALE		
Penile discharge/pain	☐	☐
Penile/scrotal swelling	☐	☐
Testicular pain	☐	☐
MUSCULOSKELETAL		
Painful/swollen joints	☐	☐
Back pain	☐	☐
Gait problems	☐	☐
Muscle pain	☐	☐
Neck pain/stiffness	☐	☐

SKIN	Yes	No
Color change/pallor	☐	☐
Rash/wound	☐	☐
ALLERGY/IMMUNOLOGIC		
Environmental allergies	☐	☐
Food allergies	☐	☐
Medication allergies	☐	☐
Immunocompromised	☐	☐
NEUROLOGICAL		
Dizziness	☐	☐
Facial asymmetry	☐	☐
Headaches	☐	☐
Light-headedness	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Speech difficulty	☐	☐
Syncope (fainting)	☐	☐
Tremors	☐	☐
Weakness	☐	☐
HEMATOLOGIC/LYMPHATIC		
Large/swollen lymph nodes	☐	☐
Bruises/bleeds easily	☐	☐
PSYCHIATRIC		
Agitation	☐	☐
Behavior problems	☐	☐
Confusion	☐	☐
Decrease in concentration	☐	☐
Uneasy mood	☐	☐
Hallucinations	☐	☐
Hyperactivity	☐	☐
Nervous/anxious	☐	☐
Sleep disturbance	☐	☐
Suicidal ideas	☐	☐

EMOTIONAL

Over the last 2 weeks, how often have you?

1. Had little or no interest or pleasure in doing things?
   ☐ Not at all ☐ Several days
   ☐ Half the days ☐ Nearly every day
2. Felt down, depressed or hopeless
   ☐ Not at all ☐ Several days
   ☐ Half the days ☐ Nearly every day

Form #10745 Rev. (06/18)

WPCF0001

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

Form A

WELLSPAN®
Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of WellSpan Health's Notice of Privacy Practices.

_____ _____

DATE SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____ _____

TIME PRINTED NAME

Please see www.wellspan.org/disclaimer-policies/hipaa-privacy for WellSpan Health Notice of Privacy Pratices.

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

Form B

WellSpan®
Medical Group

DO NOT COMPLETE IF FORM "A" HAS BEEN SIGNED

GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE

For use only when efforts to obtain acknowledgement of receipt of notice are unsuccessful

Personal representative information **(if applicable):**

_____ _____

NAME OF PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

I provided the above named patient (or patient's representative) with the WellSpan Notice of Privacy Practices.

Describe efforts to provide Notice and obtain signature:

☐ Offered copy and individual refused to accept delivery

☐ Patient/personal representative was asked to sign form and refused

☐ Patient claims they have already received the WellSpan Notice of Privacy Practices

☐ Other _____

_____

_____

_____

_____ _____

SIGNATURE DATE

_____ _____

PRINTED NAME TIME

Form #8730 Rev. (09/02/15)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

WELLSPAN® HEALTH

*** * * PLEASE READ AND COMPLETE ALL ITEMS * * ***

Patient Name: _____ **Alias/Maiden Name:** _____

Date of Birth: _____ **Last 4 of Social Security Number:** _____ **Phone Number:** _____

Address: _____

I authorize the use/disclosure of health information about me as described below:

☐ Obtain from:

To obtain from: _____
(What Hospital/Practice/Service)

☐ Disclose to: _____
(Release to What Organization/Practice/To Whom)

Address: _____

_____

Address: _____

_____

Fax No.: _____

Fax No.: _____

Share the following information from my medical record: From: _____ To: _____
(Please Specify the Dates of Service)

☐ **Abstract of Hospital Medical Records:**
History & Physical, Emergency Department Physician Notes, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, etc.

☐ **Abstract of Medical Group Records:**
Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, Psychiatric and Psychological Evaluations, Mental Health Progress Notes, etc.

☐ **Diagnostic Test Results** (please specify): _____

☐ **Imaging** (please select **one** format): ☐ **CD and Reports** ☐ **Film and Reports** ☐ **Reports Only**

☐ **Billing Statements**

☐ **Grant the following authorized user,** _____, **access to my entire Electronic Medical Record.**
This **DOES NOT** authorize the user to disclose, modify, or provide any official medical advice on my behalf.

☐ **Other** (please specify): _____

For the **purpose** of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Benefits**

☐ **Legal Investigation** ☐ **Billing Inquiries** ☐ **Establish Payment Plan**

☐ **Other** (please specify): _____

I would like to receive this information via (please select **one**): ☐ **Paper** ☐ **CD** ☐ **Secure Email Notification**

Email Address: _____

- I must provide a valid email address, either my own or that of my designated recipient.
- An email notification will be provided with instructions to retrieve the requested records from a secure portal. These records will only be available as PDF documents on the secure portal for 30 days following the date of the email Notification of Availability.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ☐ AIDS/HIV Related Information and/or Testing; ☐ Behavioral/Mental Health Services; ☐ Drug and/or Alcohol Treatment.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

_____ _____

Signature of Patient/Representative * Date

_____

Print Name of Representative and Relationship to Patient *

_____ _____

Signature of Witness Date

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above Authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

_____ _____

Signature of Witness Date

_____ _____

Signature of Witness Date

PLEASE MAIL OR FAX THIS FORM TO:

WellSpan Health
Health Information Management – Release of Information
912 South George Street
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119

*** * * IMPORTANT: Please send copies of medical records directly to the requesting practice or physician. * * ***

Requests for health information and invoices are processed by: