New Wave
Internal Medicine Clinic

Amber D. Colville, M.D. *Lydia Latour, M.D.
Danielle K. Bersabe, M.D., FACP
1135 Ocean Springs Rd
Ocean Springs, MS 39564
Phone (228)875-6695 * Fax (228)875-6696

Dear Patient,

Thank you for your interest in becoming a new patient at New Wave Internal Medicine. Please fill out the enclosed paperwork and return it with a copy of your medication list and insurance card. We will gladly call you to set up an appointment once all information is received.

We do **REQUIRE** a one-time $100.00 New Patient deposit by cash or credit card **BEFORE** the appointment can be made. Cash deposits must be brought to our office before we schedule you an appointment and you will be issued a receipt. Credit card deposits will only be charged if you No Call/No Show for your scheduled appointment and cash will be non-refundable. Please bring your receipt to your New Patient appointment and your cash deposit will be returned. If you have any questions, please call our office. We look forward to seeing you.

Thank you,

Trishten Trochesset
New Patient Coordinator

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New Patient Receipt

Date: _____

Patient Name: _____

Deposit: Cash or Credit

Deposit Amount: _____

Name on Card:_____

Credit Card Number:_____

Expiration Date:_____

Security Code: _____

_____ _____
New Wave Internal Medicine Clinic Rep Date

_____ _____
Patient Signature Date

Deposit Returned

_____ _____
New Wave Internal Medicine Clinic Rep Date

_____ _____
Patient Signature Date

Deposited Charged for No Show

_____ _____ _____
New Wave Internal Medicine Clinic Rep Amount Charged Date

_____ _____ _____
Patient Signature Amount Charged Date

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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I, _____, give the office of Dr. Amber Colville, Dr. Lydia Latour, or Dr. Danielle Bersabe permission to discuss the results of my lab work, other test and/or information concerning my medical history with:

☐ Spouse_____
(name)

☐ Parent_____
(name)

☐ Other_____
(name)

☐ I do not want information concerning my medical information discussed with anyone.

I give permission to leave a message discussing the results of my lab work, other test and/or information concerning my medical history.

☐ Yes

☐ No

_____ _____
Patient Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (*HIPAA*), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was not able to do so as documented below:

Reason: _____
Employee: _____
Date: _____

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Please select one of the following:

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Hispanic
- ☐ Other
- ☐ Refuse to Disclose

Ethnicity:

- ☐ Hispanic Latin
- ☐ Non-Hispanic
- ☐ Refuse to Disclose

Primary Language:

_____

Please initial each of the following:

_____ I consent to the treatment necessary for the care of named patient.

_____ I authorize the release and/or fax transmittal of all medical records to the referring and family physicians and to my insurance company.

_____ I have read and fully understand the above consent to treatment, release of medical records and financial agreement.

_____ _____

Patient Signature **Date**

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Assignment of Benefits

I assign payment to New Wave Internal Medicine Clinic in accepting this assignment of benefits for all therapy and applicable and otherwise payable to me but not to exceed the reasonable and customary charge for these services rendered by said group.

Agreement of Payment

I, the undersigned, do hereby understand and agree that I am responsible for all charges to my account.

I further understand that all insurance claims are filed as a courtesy by New Wave Internal Medicine Clinic as per the contractual agreement with my insurance carrier and that I am responsible for any unpaid portion of the account balance.

I understand that New Wave Internal Medicine Clinic will allow sixty (60) days for payment to be made by the insurance carrier at which time I may be held responsible for any unpaid portion of the balance.

I understand that there will be a $25.00 No Call/No Show fee if the appointment is not cancelled 24hrs before appointment time and/or if I do not show for my scheduled appointment. I understand this fee will be charged to my account and due at the time of next appointment. This will be my financial responsibility and not that of my insurance carrier.

If I am not covered by an insurance carrier, I agree that I am responsible for all charges at the time of services are rendered unless financial agreements have been made in advance.

Should my account become past due and is transferred to an attorney and/or collection agency, I understand that I will be responsible for all attorney, court and any other associated fees with the collection of this account.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

New Wave Internal Medicine Clinic Employee **Date**

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I understand that I will be charged for all requests for forms and/or letters to be completed by my physician. All fees must be prepaid. Fees are listed below.

Handicap Parking Permits: $15.00

Medical Letters: $25.00

Jury Duty Letters: $35.00

F.M.L.A / Disability Paperwork: $50.00

Medical Letters include, but are not limited to attorneys, insurance companies, employers, schools, airlines, travel agents, financial institutes, etc.

Print Patient Name: _____

Patient Signature: _____

Date: _____

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MEDICAL RECORD RELEASE TO

Patient Name_____

Address_____

City_____ State_____ Zip _____

DOB_____/_____/_____ Social Security # _____/_____/_____ Phone Number (_____)_____/_____

RELEASE RECORDS FROM

Physician Name_____

Address_____

City_____ State_____ Zip _____

Phone Number (_____)_____-_____ Fax Number (_____)_____-_____

PLEASE SEND THE FOLLOWING RECORDS

____Office Notes ____X-Rays/Radiology Report _____Labs ____Complete Medical Record

I understand the following:

- Except for the Psychotherapy notes(which are not included in my medical records), all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV will be released.
- I do not want these records released (Please list)

  _____
- If I change my mind, I will notify the specified clinic to stop the release of these records. This will not apply to records that have already been released.
- This form will expire in one year after I sign, or sooner (specify here_____). The time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing records. ($1.00 per page)
- Once records are released, the clinic or hospital releasing my records cannot prevent them from being released to a third party. At that point, the records may no longer be protected by the state and federal privacy laws.
- This facility will not release any third party records, we will only release records signed and/or ordered by the facility doctors.

Signature_____
Date_____

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PATIENT INFO

Last Name	First Name	MiddleName/Initial

Street Address	City	State	Zipcode

Primary Phone	Secondary Phone	Work Phone	Email Address

DOB	Age	Sex	Social Security #	Marital Status (Circle One)
				Single Married Divorced Widowed Other

Employer Name	Employer Address	Occupation

EMERGENCY CONTACT INFO

Emergency Contact Name	Relation to Patient	Emergency Primary Number

FINANCIAL RESPONSIBILITY

☐ Same As Above

Last Name	First Name	Relation to Patient

Social Security #	DOB	Primary Phone	Secondary Phone

Employer Name	Employer Address	Occupation

PHARMACY INFO

Pharmacy Name	Pharmacy Address	Pharmacy Phone number

INSURANCE - Please provide your insurance card(s) to the receptionist

Primary - Policy Holder's Name	Policy Holder SSN#	Insurance Company	Policy Holder DOB

Insurance Street Address	City	State	Zipcode

Policy Number	Group Number	Effective Date	Copay Amount

Secondary - Policy Holder's Name	Policy Holder SSN#	Insurance Company	Policy Holder DOB

Street Address	City	State	Zipcode

Policy Number	Group Number	Effective Date	Copay Amount

By signing below you agree that all the information provided is correct and unfalsified

Date:_____ **Signature:**_____

Medicine List
