Patient Registration / Authorization / Consent Form

Demographic Information

Pharmacy Name & Phone Number: _____

Name_____ Birth Date_____ Gender _____

Social Security # _____

Race ❒ American Indian/Alaska Native ❒ Asian ❒ Black/African American
❒ Native Hawaiian ❒ White ❒ Declined/Unreported

Ethnicity ❒ Latino/Hispanic ❒ Not Latino/Hispanic ❒ Declined/Unreported

Primary Language _____

Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Address _____City _____ State_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Primary Phone Preference ❒ Home ❒ Work ❒ Cell Email address: _____

Where do you prefer to be contacted regarding abnormal test results? ❒ Home phone ❒ Cell phone ❒ Work Phone

Preferred Method of Communication ❒ Patient Portal ❒ Text ❒ Phone ❒ Mail ❒ Other_____

Employer_____ Occupation_____

Business Address _____ Business Phone _____

Insurance Information

Primary Insurance Company _____ Policy # _____ Group # _____

Subscriber Name _____ Birth Date_____ Social Security # _____

Secondary Insurance Company _____ Policy # _____ Group # _____

Subscriber Name _____ Birth Date_____ Social Security # _____

Are you currently employed? ❑ Yes ❑ No

Are you covered under an employer or union policy? ❑ Yes ❑ No

Is this visit a Worker's comp or Auto case? ❑ No ❑ Yes – Worker's comp ❑ Yes - Auto

If Yes, work comp/auto insurance company _____

Claim # _____ Adjuster _____ Phone _____

Advanced Directives

Do you have a signed Power of Attorney or Medical Directive? ❑ Yes ❑ No

If yes, designated surrogate decision maker (name) _____

Do you have a living will? ❑ Yes ❑ No

Legally Responsible Adult/Guardian/Healthcare Proxy (if applicable):

Name _____ Relation to Patient _____

Address _____City _____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Referral Source

How did you hear about us?

❑ Doctor/Referring Provider _____

❑ Hospital _____

❑ Family/Friend _____

❑ Practice Website ❑ Internet Search ❑ Insurance Company

❑ Advertisement/Event _____

❑ Other (Please Specify)_____

Primary Care Physician & Phone Number: _____

Communication Consent

HIPAA Notice of Privacy Practice: I certify that a copy of the Notice of Privacy Practices has been made available to me. In order to comply with the Health Insurance Portability & Accountability Act of 1996, please complete the following communication consent.

EMERGENCY CONTACT: The practice will not release confidential information by home telephone, answering machine, work telephone, voice mail or cell phone unless authorized below. Designating an emergency contact is not considered authorization to disclose confidential information. Confidential information will not be left with an unauthorized person who may answer the telephone. Who may we contact in case of emergency?

Name: _____ Phone #: _____

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION (PHI): I authorize the practice to contact me and/or authorized person(s) designated below and convey private and confidential health information. I assume the responsibility to notify the practice whenever this information changes. I am authorizing a **detailed message, including information that may be construed as PHI,** to be left with the individual listed below.

Please list name/relationship of other people authorized to receive information about your care:

Name: _____ Relationship: _____ Phone #: _____

General Consent for Treatment

I hereby authorize the healthcare providers of the practice and his/her staff, to perform and do hereby consent to such medical treatment as he/she feels is necessary, including diagnostic procedures, medical examinations, and treatment that may, in his/her opinion, be medically necessary. I consent to the testing for infectious diseases, including but not limited to, syphilis, HIV, hepatitis and testing for drugs if deemed advisable/recommended by my healthcare provider.

I understand that I have the right to opt-out of or decline any specific diagnostic procedures, medical examinations, treatment options, and testing, including HIV screening at any time. I understand that written certification is required to opt-out of HIV screening at the time testing is recommended.

I certify that I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the result of any procedure, treatment, or examination.

I understand that my confidential health information will be disclosed for the purposes of treatment, payment, and/or practice operations, consistent with the HIPAA regulations set forth by the Office of Civil Rights (OCR).

Payment Authorization and Financial Statement

I authorize the assignment of insurance benefits to Providea Health Partners, LLC and understand and acknowledge that ***I am responsible for payment of all items and services provided to me by the practice, regardless of insurance benefits or information provided to me by the practice. I also understand that it is my responsibility to contact my insurance company to verify benefits and coverage.*** I acknowledge that my account must be kept current and any past due balances are due prior to my next visit. Failure to pay outstanding balances may result in the rescheduling of an appointment. Co-pays and deductibles will be collected at the time services are rendered. In the event of nonpayment, I understand I am responsible for collection, attorney, and any court costs. All accounts with balances over $10.00 must make payment arrangements prior to scheduling future appointments

I certify that the above information provided by me is correct. I agree to notify the practice of: (1) a change in my address, guarantor, or insurance status; (2) my admission to a hospital or skilled nursing facility; (3) any change in my ability to pay for items and services provided to me by the practice or any change that effects third party reimbursement of these items and services. I understand that by signing this document, I am financially responsible for this account.

No-Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. At the discretion of the practice, if an appointment is not cancelled at least 24 hours in advance, you will be charged a fee; this will not be covered by your insurance company. The fee for no-show will vary dependent on the type of appointment missed.

AFFIRMATION:
This consent and assignment of benefits will remain in effect until revoked in writing. A photocopy of this consent and assignment of benefits is considered to be the same as the original.

By signing below, I acknowledge that I have read, understand, and agree to the information detailed in the Communication Consent, Payment Authorization and Financial Statement, General Consent for Treatment, and No Show Policy.

_____ _____

Signature of Patient
(If minor, Signature of Responsible Party)

Date