Patient Registration Form

Is today's visit work related?
If yes, do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? ☐ Yes ☐ No How did you hear about us? _____

What's the reason for your visit today? _____

PATIENT INFORMATION

Name: ☐ Male ☐ Female
Date of Birth: SS#:
Mailing Address: Apt#:
City: State: Zip:
Home Ph#: Cell Ph#:
*Confidential Phone:
Home Email:
*Confidential Email:

Primary Care Physician (PCP):
PCP Address:
PCP Ph#:
Preferred Pharmacy:
Pharmacy Ph#:
Sexual Orientation:
Gender ID:

For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:
Relationship:
Home Ph#:
Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:
Race: ☐ I prefer not to answer
Ethnicity: ☐ I prefer not to answer
Best Form of Contact: ☐ Cell ☐ Home ☐ Email ☐ Mail
Best Time to Call: May we leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Ins: Ins #:
Name of Insured:
Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:
Name of Insured:
Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female
Date of Birth: SS#:

Relationship:
Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature Date

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature Date

Consent for Electronic Communication and Credit Card on File

ELECTRONIC COMMUNICATION

Text Message and Informed Consent: In order to enhance patients' care and experience, we may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voice mail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you. In addition, based on your feedback, we may anonymously identify statements or comments that might help other potential patients choose to receive their treatment with us. By checking the box below and signing this consent, you acknowledge and agree that these comments and/or statements may be used on an anonymous basis on our website only, purely for providing those who may view the website with objective reviews of our care.

Mobile Safety Tips: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

1. Use a password on your mobile device to prevent strangers from seeing what is on your phone.
2. Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.
3. If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

I acknowledge that I have read and fully understand this consent form. I understand that by selecting no, I am selecting to not receive electronic communications. In addition, I recognize that by selecting no, that I may still receive electronic communications from the provider if required by federal, state, or local law. By signing below, I acknowledge that I have read and fully understand this consent form, including the risks associated with the communication of E-mail, SMS messages, and other forms of electronic communication; and I consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate through E-mail, SMS, and/or other forms of electronic communication.

Please contact me using electronic communication ☐ Yes ☐ No

My anonymous feedback may be used on your website ☐ Yes ☐ No

Signature of Patient/Patient Representative _____ Date _____ Confidential Cell Phone Number _____

PATIENT PORTAL CONSENT

The patient portal is an internet-based tool that allows our patients to view and access their health records. The patient portal may not contain a complete co py of your health records at all times. We have the right to restrict disclosure of certain records to you under federal and state law. By providing a confidential email address below, you agree that we may send to that email address a confidential user ID and passwo rd or a link to create a confidential user ID and password which will provide you access to the patient portal. You agree and understand that protection of this confidential login informatio n is up to you and not our responsibility once we have provided you with the initial email. You further acknowledge that we will use this email address as our means of communicating to you re garding information sent to the patient portal. Communicating via the patient portal is not intended for medical treatment purposes . If you have a life threatening emergency, please call 911 and seek medical attention immediately.

By signing below, I acknowledge that I have read and fully understand the patient portal terms listed above. I acknowledge th at I am at least 19 years of age and that I am requesting access to the patient portal. I acknowledge that the patient portal is offered as a courtesy to our patients and I agree that you may terminate your access to the portal at any time for any reason, with or without notice.

I authorize you to send my medical records, through the patient portal, to the confidential email address below ☐ Yes ☐ No

Signature of Patient/Patient Representative _____ Date _____ Confidential Email Address _____

CREDIT CARD ON FILE CONSENT

We use a service that gives us the ability to save your credit card, debit card or health savings account card on file. This is a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are responsible. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the c laim has paid and posted to your account. An itemized statement will be mailed to you specifying insurance payments and the patient responsibility amount char ged to your card. To cancel, I must give a 30 day notification and my account must be in good standing. . I agree to pay the costs for any returned or challenged payments.

I authorize you to keep my card on file: ☐ Yes ☐ No

I, the undersigned, authorize my credit/debit card to be charged for balances due for services rendered that my insurance com pany identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me.

I request that I am contacted prior to any charges in excess of: ☐ $100 ☐ $200 ☐ $500 ☐ No Limit

Card Type (check one): ☐ Visa ☐ MC ☐ Amex ☐ Discover

Signature of Patient/Patient Representative _____ Date _____