Grayson Family Care, LLC
your health is our priority

GRAYSON FAMILY CARE PATIENT REGISTRATION

FORM MUST BE COMPLETED IN FULL

PERSONAL DETAILS

FIRST NAME				LAST NAME		M.I.	
D.O.B.		SS#		GENDER		AGE	

MARITAL STATUS		MARRIED		SINGLE		WIDOWED		DIVORCED	

CONTACT DETAILS

STREET					
CITY		STATE		ZIP CODE	
HOME PHONE		CELL		WORK	

PRIMARY PHONE		HOME		CELL		WORK	
REMINDER TO		HOME		CELL		WORK	
EMAIL ADDRESS							

PREFERRED CONTACT METHOD		PHONE		EMAIL		MAIL	
PRIMARY LANGUAGE		ENGLISH		SPANISH		OTHER_____	

RACE		ASIAN/ PACIFIC ISLANDER		BLACK		NATIVE AMERICAN	
		WHITE		OTHER		DECLINE TO SPECIFY	

ETHNICITY		HISPANIC OR LATINO		NON-HISPANIC OR LATINO		DECLINE TO SPECIFY	

EMPLOYMENT

EMPLOYER		TITLE		#OF YRS	

EMERGENCY CONTACT

FIRST NAME		LAST NAME	
DAYTIME PHONE		RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

PRIMARY INSURANCE		POLICY #			
NAME OF INSURED		RELATIONSHIP		DOB	
SECONDARY INSURANCE		POLICY #			
NAME OF INSURED		RELATIONSHIP		DOB	

PHARMACY INFORMATION

PHARMACY NAME		PHONE #	
PHARMACY ADDRESS			

ASSIGNMENT OF BENEFITS - GRAYSON FAMILY CARE LLC

I _____The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby assigns and conveys directly to GRAYSON FAMILY CARE (the "Provider"), all medical benefits and/or insurance reimbursement, if any, otherwise payable to the Patient for services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all healthcare and/or surgical benefits which the Patient is entitled to receive under the Plan, and authorizes the Provider to release all medical information necessary to process the Patient's claims.

I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card or insurance information. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and the provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider . I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for all professional services from the Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise proactively arranged with applicable PPO or ACA discount. I am fully protected against any unexpected medical bills or charges by my provider's ACA or indigency discount under the above provider's indigency Policy, for any payor compliant PPO Discount or Non-PPO Re-pricing Discount from my health insurance plan from my health insurance or plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for my ASA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative, and a PPACA or ERISA claimant, to claim or legally pursue for the proper reimbursement from my health insurance or plan.

I hereby authorize the Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I authorize Provider, its designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my appeal or health care services, wholly in my stead. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all Plan and relevant claim documents, requested disclosures, administrative claim files, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including filing, providing or receiving notice of any appeal proceedings; (5) act as my authorized representative in connection with any request for external review by applicable state or Federal External Review Process. I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain external review information; and to receive any notice in connection with my external review, wholly in my stead. (6) Participate in any administrative review process, including but not limited to review fiduciary duties involving the administration of benefits. I understand that I will be held financially responsible for all collection agency fees, administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____ _____

Patient/Guardian/Insured Signature **Insurance/Group Name Covering Benefits** **Date**

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MEDICAL INFORMATION RELEASE AUTHORIZATION

As your provider, we are committed to maintaining the privacy of your healthcare information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize GRAYSON FAMILY CARE LLC to contact me regarding my medical information by means of the listed methods. I will also be responsible for contacting the office should this information change.

Home telephone #:_____
May we leave messages on your home answering machine? Yes No

Work telephone #:_____
May we leave messages on your work voicemail? Yes No

Cell phone #:_____
May we leave messages on your cell phone voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people:

- All test results Yes No
- The entire medical record Yes No
- Most recent visit Yes No
- Financial information Yes No
- Pick up prescriptions on my behalf Yes No

Spouse: Yes No Name:_____

Parent(s): Yes No Name(s):_____

Children: Yes No Name(s):_____

Other: Please give name and relationship (aunt,uncle,cousin, friend,etc)

Name:_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.

Patient Name (printed)_____ Date of Birth:_____
Patient/parent/guardian signature: _____
Date signed:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name & Date of Birth:

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____

Signature Date

BELOW FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

_____

❑ Other:_____

Prepared By _____

Signature _____

Date _____

PATIENT MEDICAL & PROCEDURE HISTORY

PATIENT DETAILS

LAST NAME		FIRST NAME		MI	
D.O.B		TODAY'S DATE			

MEDICAL HISTORY

REASON FOR VISIT	

CURRENT MEDICAL CONDITIONS (i.e., DIABETES, HEART DISEASE, etc.)

MEDICAL PROCEDURES & TESTS

MEDICAL PROCEDURES & TEST HISTORY: INDICATE YES/NO/NOT APPLICABLE (NA) & DATE							
COLONOSCOPY		DATE		EYE EXAM		DATE	
MAMMOGRAM		DATE		BONE DENSITY (DEXA SCAN)		DATE	

IMMUNIZATION HISTORY

IMMUNIZATION HISTORY: INDICATE YES/NO & DATE							
COVID		DATES		PNEUMONIA		DATE	
FLU		DATE		SHINGLES		DATE	

PATIENT/LEGAL GUARDIAN SIGNATURE		DATE	

SURGICAL HISTORY

SURGICAL HISTORY: PLEASE LIST RECENT SURGERIES AND DATES

TYPE OF SURGERY	DATE

MEDICATIONS

MEDICATIONS LIST: PLEASE LIST ANY MEDICATIONS YOU ARE TAKING AND RESPECTIVE DOSAGE

MEDICATION	DOSAGE

PATIENT/LEGAL GUARDIAN SIGNATURE		DATE	