Patient Registration Form – Allcare Medical Clinic

PATIENT'S NAME:_____
Last name First name Middle

☐ **Male** ☐ **Female** ☐ **Child** ☐ **Unmarried** ☐ **Married** ☐ **Separated**

Address:_____
(Number & Street) Apt # City (State/Zip)

Patient's Employer_____
(Name & Address)

Parent/Spouse's Name: _____Soc. Sec. #_____

Parent/Spouse's Employer: _____ Phone #_____
(Name & Address)

RELATIVE WE CAN CONTACT IN CASE OF EMERGENCY:

Name_____ **Phone#**_____
(Last) (First) (Middle)

Relationship (*with patient*)_____

Address _____ City_____ State/Zip_____

How were you referred to our clinic? (Please check)
☐Web/online ☐Yellow Pages ☐ Employer ☐ Doctor/Hospital
☐ Friend/Family ☐Person/other_____

HOW ARE YOU PAYING FOR SERVICES RENDERED (*Check one or more***)**
☐ Cash ☐Check ☐ Visa ☐ Master Card ☐ Insurance ☐ Medicare ☐Other

(Present Your Insurance Card(s) as well)
Primary Insurance Name_____ Effective date_____
Secondary Insurance Name_____ Effective date_____

Birth Date:
Soc Sec #:
Home#:
Cell#:
Email:
Emergency Contact #:
Can we call you at work? **If Yes,** Work phone#

Race & ethnicity questions

"The purpose for race & ethnicity data collection is to enable us to meet requirements for meaningful use of electronic health records and to assure high quality care for all our patient populations." Thank you.

1. Are you spanish/Hispanic/Latino?
☐Yes ☐No ☐Refused/don't know
2. What race you consider yourself to be? *(Mark one or more races to indicate your response)*
☐ American Indian / Alaskan Native,
☐ Asian,
☐ Black or African American
☐ Hispanic
☐ Native Hawaiian or Other Pacific
☐ Other race
☐ White
☐ Declined to report/don't know
3. Your preferred Language(s):
☐ English ☐_____

HIPPA COMPLIANCE: By my signature below, I acknowledge the receipt of &/or have read the Notice of Privacy Practices (NPP) which describes in detail how your health information may be used and disclosed, and how you can access this information. (Ask for a copy of privacy Notice if you did not see or receive one)

FINANCIAL AGREEMENT AND AUTHORIZATION FOR DIAGNOSIS/TREATMENT:

I hereby authorize Clinic, its providers (MD, PA, ARNP) and staff to perform/assist with the necessary test(s) and procedure(s) for the health assessment and treatment of myself and/or my children (or minor), and to furnish/exchange the information to/from other providers. I agree to pay all fees and charges for such procedures & treatments. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of service/first billing date. In the event, legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court or other agency determines proper. It is also agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this clinic where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) Charge for returned check is $30 & Billing/Finance charge is 1% of balance (Mini. $2.00)

AGREEEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification, if desired by the creditor.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of this agreement at the time you sign.

Signature_____ **Date**_____
PERSON RESPONSIBLE FOR PAYMENT RELATIONSHIP WITH PATIENT