PATIENT REGISTRATION

| PLEASE PRINT AND COMPLETE ALL ENTRIES | | |
|---|---|---|
| PATIENT NAME (LAST, FIRST, M.I. ) | | DOB |
| ADDRESS | CITY, STATE, ZIP | |
| PHONE NUMBER | SEX (CIRCLE ONE)<br>MALE FEMALE | MARITAL STATUS (CIRCLE ONE)<br>S M W D SEP |
| INSURED/RESPONSIBLE PARTY: RELATION TO PATIENT (CIRCLE ONE) SPOUSE PARENT GUARDIAN | | |
| NAME | PHONE NUMBER | DOB |
| AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY MEMBERS OR FRIENDS | | |
| NAME | RELATION | PHONE NUMBER |
| NAME | RELATION | PHONE NUMBER |
| NAME | RELATION | PHONE NUMBER |
| RELEASE THE FOLLOWING INFORMATION: (CIRCLE ONE) | | |
| ALL RECORDS CHART NOTES RADIOLOGY | | |
| IMMUNIZATION RECORDS MEDICATION INFORMATION | | |
| DO WE HAVE PERMISSION TO LEAVE YOU A MESSAGE ABOUT YOUR RESULTS, APPOINTMENTS OR OTHER MEDICAL INFORMATION? (CIRCLE ONE) YES NO | | |

ACKNOWLEDGEMENT OF APPOINTMENT CANCELLATION POLICY

Klein Medical Clinic have policies in regards to missed or same day cancellation visits. An appointment cancelled with less than 24 hours notice, significantly limits our ability to make appointments for another patient in need. We ask the following:

1.Please give 24hr notice in the event you need to cancel or reschedule your appt.
2.If you are 15 minutes late to your appt, the appointment will be rescheduled.
3.A “no show/no call” missed appt without 24hrs notice may be assessed a $50.00 fee.
4.As a courtesy we do attempt to call the day before the schedule appt to confirm with you.

PATIENT SIGNATURE: DATE:

Klein Medical Clinic

HIPAA Information and Consent Form

The health insurance portability and accountability act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a friendly version. A more complete text is available in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provide certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality, professional service and care. Additional information is available from the US Department of Health and Human services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies as a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, exam rooms etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduction of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to the records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to you request.

I_____ do hereby consent and acknowledge my agreement to the terms set forth in
(Patient name)
the HIPAA INFORMATIOIN FORM and any subsequent changes in office policy/ I understand that this consent shall

remain in force from this time forward.

Date:_____

Klein Medical Clinic
Acknowledgment of Financial Responsibility

Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, co-pay, or any other balance not paid for by your insurance. A current copy of your insurance card is required at each visit, if a current copy is not provided or if the information given is incomplete and/or cannot be verified, the patient must be considered Private Pay and will be required to pay for each visit in full at the time of service until valid information is supplied.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE BEGINNING OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

*I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM ON MY BEHALF. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.*

I certify that all of the information given at registration is true and correct to the best of my knowledge. I understand that knowingly falsifying information upon registration is cause for dismissal as a patient of this clinic. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, Private Insurance, and other Health Plans to the practice as stated upon registration. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Patient Name (PRINTED) Patient DOB

Emergency Contact Name and Number

Signature of Patient, Guardian, or Legal Representative Date

Printed Name of Guardian or Legal Representative if not Patient (PRINTED)

NOTE: THIS FORM MUST BE UPDATES EVERY 6 MONTHS AND/OR ANYTIME THERE IS A CHANGE IN PATIENT AND/OR INSURANCE INFORMATION…NO EXCEPTIONS!

Klein Medical Clinic

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

**Patient Name:**_____ **Date of Birth:**_____

**Phone: H)** _____ **Phone: W)** _____

**Address:** _____ **City/State/Zip:** _____

**Please Note:** Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

**Facility Name:** _____ **Facility Phone:** _____

**Facility Address:**_____ **Facility Fax:**_____

**City, ST, Zip:** _____

**Dates and Type of information to disclose:**

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

**The purpose of disclosure is**:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**This information may be disclosed and used by the following individual or organization:**

**Release To:** _____

**Address:** _____

**City, State, Zip:** _____ ☐ **Please mail records.**

☐ **Please fax records.**

**Fax:** _____ **Phone:** _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

**X**_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

**Date**

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative