ALEXANDER MEDICAL ASSOCIATES
REGISTRATION FORM

(Please Print)

Preferred Name: PCP:

Patient Information

Last Name: Middle: First:

Date of Birth: Sex: ☐ M ☐ F Social Security #:

Home Phone #: Work #: Cell #:

Email Address:

Mailing Address: City, State: Zip Code:

Do you have a living will? Yes No If no, would you like information about it? Yes No

Spouse or Parent Information (if minor)

Name: Date of Birth:

Address: ☐ Same as above
☐ Other:
Phone #:

Insurance Information

Person Responsible for bill:
☐ Self
☐ Other: ________________________________

Date of Birth:

Phone #:

Address: ☐ Same as above ☐ Other:

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance: ☐ BCBS ☐ Cigna ☐ Humana ☐ United Healthcare ☐ Other: ________________________________

Subscriber's name: ☐ Self ☐ Other: __________________________ Date of Birth:

Name of secondary insurance (if applicable): Subscriber's name:

Pharmacy Information

Pharmacy Name: Phone: Location:

In Case of Emergency

Name: Relationship to patient:

Home phone #: Cell Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Alexander Medical Associates or insurance company to release any information required to process my claims.

____ ___________________________________

Signature (if minor, parent/guardian must sign) Date

Alexander Medical Associates

____________________________________ give permission to the Physicians and their staff at Alexander Medical Associates to leave messages regarding my care in the following manner when I am unavailable.

(PLEASE MARK ALL THAT APPLY)

___ May leave appointment reminders on my voice mail

___ May leave appointment reminders with my family

___ May leave lab results on my voice mail

___ May leave lab results with emergency contacts listed

___ May leave general questions/information on my voice mail

___ May leave general questions/information with my family

Family and/or other contacts include:

____

____

____

(Please list anyone who may discuss your health care with our office)

___ May ONLY leave information with myself. (Please note, if you check here, there should be no other choices checked)

I would prefer to be contacted at this number: ______________________________________

CANCELLATION POLICY

If you must cancel or reschedule your appointment, we would appreciate at least a 24-hour notice. There will be a fee if proper notice is not given for "no-show" visits.

APPOINTMENT TIMES

Please arrive for your appointment at least 15 minutes early to ensure verification of insurance and the proper forms are complete.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification. I received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures on my PHI.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the HIPAA policy.

PATIENTS NAME OR LEGAL GUARDIAN: ____

SIGNATURE: ____ DATE: _________________________