Rincon Medical Center

New Patient Information Sheet

Today's Date __________________

Patient Name ____DOB___________________Age______

☐ **Result of a vehicle accident** ☐ **Result of a work related injury**

Symptoms for today's visit: ____

When did symptoms begin____________________ Pain Scale (1=mild - 10=Extreme) ______________

What medications are you currently taking?

Medicine Name	Dosage	Frequency

Are you allergic to any medications? ______If Yes, please List _________________________________

Would you be interested in filling your prescription within the office? No ☐ Yes ☐ (**$10.00 per medication**)

When was your last normal period?____________ Are you pregnant? _______ Are you breastfeeding?_________

Who is your Primary Care Physician? ____

Past Medical History, please list ____

____

Surgical History, please list ____

Family Medical History ____

Tobacco Use: No ☐ ☐ Yes If yes, how much daily____

Alcohol Use: No ☐ ☐ Yes If yes, how much daily____

Drug Use: No ☐ ☐ Yes If yes, what and how much daily________________________________

The signature below serves as authorization for medical treatment by the physician or nurse. It also provides authorization to **Rincon Medical Center** to furnish and/or release any information necessary to your insurance carrier, third party administration, and or health benefit payer representatives in order to process health care claims. This authorization also serves as permission to release my medical records to my designated primary care physician's office to ensure continuity of care. . I understand that I may withdraw this authorization to release medical information at any time, when I communicate in writing. I acknowledge that **Rincon Medical Center** will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I am financially responsible at the time of service for all co-payments, deductibles, balances not covered by the insurance carrier, and any previous balances owed.

Patient/Responsible Party Signature_____________________________________ **Date**_______________

Physician Signature____ Date____________________

Rincon Medical Center

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	City:	State:	Zip Code:
Mailing or P.O. Box (If Different from Street Address):	City:	State:	Zip Code:

Home Phone No: ( )	Employer Phone No: ( )	Mobile Phone No: ( )	Student: ❑ Yes ❑ No	Employed: ❑ Yes ❑ No

Birth Date: / /	Age:	Sex: ❑ M ❑ F	Social Security no.:	E-mail Address:	Employer

Parent/Guardian (If patient is under the age of 18)

Parent/Guardian Name):	Social Security no.:	Birth Date: / /	Age:	Contact Phone No: ( )

Mailing Address (If Different from Above):	City	State:	Zip:

INSURANCE INFORMATION

Primary Insurance Carrier:

Subscriber's Name:	Birth date: / /	Social Security No.:	Contact Phone No: ( )

Is this person a patient here? ❑ Yes ❑ No	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other - Specify:

Mailing or P.O. Box (If Different from Above):	City:	State:	Zip Code:

Secondary Insurance Carrier:

Subscriber's Name:	Birth date: / /	Social Security No.:	Contact Phone No: ( )

Is this person a patient here? ❑ Yes ❑ No	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other - Specify:

Mailing or P.O. Box (If Different from Above):	City:	State:	Zip Code:

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 Rincon Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Rincon Medical Center

Billing Policy

The following sets forth the general billing policy of Rincon Medical Center. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Rincon Medical Center with current, accurate billing information at the time of check in and notify RMC of any changes in this information.
- I understand that it is my responsibility to know my urgent care co-pay (which can be different than my Primary Care co-pay) and to pay it prior to services being rendered. I understand that it is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failure to pay the co-pay.
- I understand that if I present an insufficient fund check (NSF Check) for payment on my account that I will be charges a $35 NSF fee. I further understand that to rectify my account, I will be required to pay cash, a money order, cashier's check, or credit card.
- I understand that the clinic will verify my insurance eligibility, copays, deductible amounts, and coinsurance amounts prior to any examination.
  I will be billed for any amounts due by me (copay, coinsurance amounts/deductibles as specified by insurance after billed) and that I have a financial responsibility to pay these amounts. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that if I do not have health insurance, it will be my responsibility to pay Rincon Medical Center the full and entire amount due before services are rendered.

Consent for Treatment and Authorization to Release Information

- I understand I hereby authorize Rincon Medical Center, through its appropriate personnel, to perform or have performed upon me/ patient, appropriate assessment and treatment/ procedure.

I further authorize Rincon Medical Center, to release to appropriate agencies; any information acquired in the course of my/patient's examination and treatment.

Patient Consent for Use and Disclosure of Protected Health Information

- I hereby give my consent for Rincon Medical Center to use, and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO).
- (Rincon Medical Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Rincon Medical Center reserves the right to revise the Notice Of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rincon Medical Center, 119 Chimney Road, Rincon, GA 31326.
- With this consent, Rincon Medical Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and Confidential.
- However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

My signature below confirms:

I have read the billing policies and my financial obligation as pertains to the providers of Rincon Medical Center.
I have read and authorize Consent for Treatment and Information Release.
I am consenting to Rincon Medical Center's use and disclosure of my PHI to carry out TPO.

- ❖ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rincon Medical Center may decline to provide treatment to me.

____ _____________________________________

Legal Signature **Date**

____

Relationship to Patient

<u>Please notify the front desk staff if you would like a copy of our Notice of Privacy Policies.</u>

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Patient Name: ____________________________**Date of Birth:** ______________
Responsible party name: ______________________ **Date of Birth:** ______________

Release of Information

I authorize the release of information including the diagnosis, records, and/or examination rendered to me and claims information. This information may be released to the following individuals:

(Please print names)

____DOB ___________relationship _________________

_______________________________________DOB ___________relationship _________________

____DOB ___________relationship _________________

____DOB ___________relationship _________________

❖ If you DO NOT want information to be released to anyone.
________(Initial)

This ***Release of Information*** will remain in effect until terminated by me in writing.

Sign: ____ **Date**: _______________________

Race and Ethnicity

Race:

- Declined
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other

Ethnicity:

- Declined
- Hispanic or Latino
- Not Hispanic or Latino

Office use only: ____ Date: ___________________