PATIENT REGISTRATION FORM

Date _____ **Chart #(office use):** _____ **Office Staff:** _____

PATIENT INFORMATION
(Please Print)

Patient's Name _____ _____ Male _____ Female

Address _____

City/Town _____ State _____ Zip Code _____

Date of Birth _____ Social Security Number _____

Home Phone _____ Cell Phone _____

Email _____ Marital Status _____

Employer's Name _____Employer's Phone _____

Employer's Address _____

Mother's Name/DOB (if patient is under age 21) _____

Father's Name/DOB (if patient is under age 21) _____

Name of Primary Insurance _____Group Number: _____
Policy Number_____

Name of Secondary Insurance _____Group Number_____
Policy Number_____

Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

Race: _____White _____Black/African American _____Native Hawaiian/Other Pacific Islander
_____American Indian/Alaska Native _____Asian _____Declined/Unknown __Other_____

Ethnicity: _____Hispanic/Latino _____Not Hispanic/Latino _____Decline/Unknown

Preferred Language _____

Chart #: _____

GENERAL MEDICAL HISTORY

PATIENT'S NAME _____ DOB _____MALE _____ FEMALE _____

PRIMARY CARE DOCTOR _____ PHONE NUMBER_____

PHARMACY/ADDRESS_____ PHONE NUMBER_____

MEDICATIONS YOU ARE CURRENTLY TAKING (PLEASE INCLUDE OR ATTACH COMPLETE LIST):

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

Do you have a **LATEX ALLERGY**? YES_____ NO_____

Do you wear glasses ____YES ____NO Contacts ____YES ____NO

Women- Last Menstrual Cycle: _____

Please check if you have ever had the following:

___ AIDS/HIV
___ Asthma
___ Allergies
___ Acid Reflux-GERD
___ Depression
___ Anemia
___ High Blood Press.
___ TIA/Mini Stroke
__ COPD/Emphysema
___ Ulcerative Colitis/Crohn's
___ Atrial Fibrillation
___ Congestive heart failure
___ Stroke
___ Glaucoma
___ High Cholesterol
___ Seizure Disorder
___ Diverticulitis
___ Anxiety
___ Cancer – type: _____
___ Diabetes – type 1 or 2: _____
___ Heart Disease/Heart Attack
___ Arthritis
___ Hernia – type: _____
___ Thyroid Disease
___ Mental Illness: _____
___ Fibromyalgia
___ Chronic Pain- Location: _____

Please Identify Other Medical Issues: _____
_____

Please check off if you have ever had any of these surgeries:

___ Appendix ___ Heart Stent ___ PE / Ear tubes ___ Gallbladder ___ C-section ___Hernia
___ Tonsils ___ Splenectomy ___ Gastric Bypass ___ Mastectomy ___ Pacemaker
__Hysterectomy ___ Ovaries ___ Prostate __
Heart Bypass ___ Joint Replacement: ____

Other: _____

Have you had any recent hospitalizations? If so, please list with related dates: _____
_____

Please check off if you have a family history of the following: Please list relationship

___ Unknown _____ Adopted _____ Addiction _____ Cancer _____ Diabetes
_____ Heart Disease _____ High Blood Pres. _____ Mental Illness _____ Stroke
_____ High Cholesterol___ Other – Please Identify _____

Smoke: ___ Never ___ Former ___ Less than 10 cigarettes a day ___ More than 10 cigarettes a day
Drink alcohol: ___ Denies ___ occasionally ___ Heavily
Drug Use: ____ Denies Drugs ___ Former Drug User ___ Current Drug User
If yes, please list: _____

Patient HIPAA Awareness

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below.

This waiver authorizes Marshall Primary Care to send/give medical information as noted:

Patient Name (First)_____ (Last)_____ (Please Print)

Please answer the following. Circle Yes or No.

1. ***YES or NO*** Leave a voice mail/text recording including my Personal Health Information on my home/cell phone.

2. ***YES or NO*** Speak to an individual of my choosing (Personal Representative) regarding my Personal Health and Billing Information and permit him/her to receive prescriptions and/or test results on my behalf.

   Name of Personal Representative_____

   Relationship_____

   Phone Number _____

3. ***YES or NO*** Speak to an individual in the event of a medical emergency. _____ (Check if same as above)

   Name of Emergency Contact_____

   Relationship_____

   Phone Number_____

4. ***YES or NO*** Send an email or text message notifying me to contact the office to discuss my lab/test results (we will ***not*** send Personal Health Information over the internet).

   Email address _____

   Cell Phone #: _____

On this date_____, I received/reviewed Marshall Primary Care Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.
The authorizations made above will remain in effect until I notify Marshall Primary Care in writing, by certified mail, of requested changes.

_____ _____
Signature of Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Today's Date

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Marshall Primary Care (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

PLEASE INITIAL ALL

All charges for services rendered are due and payable at the time of service.

_____ I am responsible and expected to pay Marshall Primary Care for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier
5. Any fee for paperwork/letters completed by the physician/CRNP (FMLA, medical letters, etc.)

_____ **Co-Pays:** All co-pays are due at the time of service. If your insurance requires any additional co-pays you will be responsible for payment and will be billed for it.

_____ **Authorization to pay benefits to the provider:** Any and all insurance checks that may go directly to the patient MUST be signed over to Marshall Primary Care for payment for services rendered. Failure to do this, will result in the patient receiving a bill for services. I hereby authorize payment for medical services provided directly to a Marshall Primary Care provider. If I should receive any insurance payments, I am to sign the check over to Marshall Primary Care.

_____ **To obtain Payment for Treatment:** We may use and disclose your PHI (Protected Health Information) in order to bill and collect payment for the treatment and services provided to you. We reserve the right to disclose your information to our business associates such as billing companies, claim processing companies, collection agencies, and others that process our healthcare claims.

_____ In the event the charges incurred are not paid in full when due, and collection activity is instituted, whether by a collection agency or an attorney (or both), **I agree to be responsible for, and pay**, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty percent (30%).

_____ In the event a check is returned due to insufficient funds, a closed account, or any other reason, a **$30.00** returned check fee will be charged. This fee is in addition to any fees your financial institution may impose. Payment of the original amount plus the $30.00 fee must be made within 5 business days of notification. Accepted forms of repayment include cash, money order, or certified funds only. Failure to resolve the returned check may result in further collection action and/or termination of services.

_____ **Marshall Primary Care** reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions who may report unpaid balances to credit bureaus.

_____The provider of service has the right to **terminate** services based on noncompliance of this agreement.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Marshall Primary Care.

Patient Name: _____ Date: _____

Signature of Patient/Guardian: _____