Patient Registration Form

Patient Information

Legal Name_____

Other/Previous Names Used_____

Address_____

City_____St_____Zip_____

Telephone (H)_____(C)_____ (W)_____

OK to Leave Message on___(H)__(C)__(W) OK to Discuss Billing Info on Cell Phone: Y / N (Circle)

Birthdate___/___/___ SS#____-____-_____ Sex: M / F (Circle) Advance Directive: Y / N (Circle)

Email_____ Interested in Patient Portal: Y / N (Circle)

Race_____Language:___English___Spanish___Other_____

Marital Status_____Occupation_____

Employer_____Address_____

Responsible Party If Other Than Self

Name _____SS#____-___-_____DOB___/___/___

Address_____City_____St_____Zip_____

Relationship to Patient_____Employer_____

Telephone (H)_____(C)_____ (W)_____

Primary Insurance

Ins Company_____

Insured Birthdate (Required) ___/___/___ SS#____-___-_____

Relationship to Patient_____Family Policy Y/N (Circle)

Secondary Insurance

Ins Company_____

Insured Birthdate (Required) ___/___/___ SS#____-___-_____

Relationship to Patient_____Family Policy Y/N (Circle)

Emergency Notification/Next of Kin/Not Living with You

Name _____DOB___/___/___

Address_____City_____St_____Zip_____

Relationship to Patient_____Employer_____

Telephone (H)_____(C)_____ (W)_____

How Did You Hear About Us? _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S). I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I GIVE THIS PRACTICE PERMISSION TO TREAT THE ABOVE PATIENT, OR MYSELF.

I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN PLACE OF THE ORIGINAL.

_____ _____/_____/_____

Signed (Patient or Representative) Month Day Year

Patient Request for Release of Protected Health Information

Family Medicine East, Chartered
1709 S. Rock Road
Wichita, Kansas 67207

Check One:

□ I hereby give my permission for Family Medicine East, Chartered to give out protected health information regarding my treatment to the individuals listed below.

□ I do not give my permission for Family Medicine East, Chartered to give out protected health information regarding my treatment to anyone other than myself.

Patient Information

Name: _____

Address: _____

Phone: _____

Work Phone: _____

Individuals to Release Information to	Relationship to You	Info to Be Released
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please specify info to be released.
For example:
any/all, billing only, pick-up only, etc.
If left blank, we will assume "any/all"

_____
Patient's Signature

_____
Signature of Employee

_____
Date

Authorization valid for 1 year from date of Signature.

I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Family Medicine East, Chtd.'s Notice of Privacy Practice by mailing or hand delivering written notification to the following person: Privacy Officer, 1709 S. Rock Road, Wichita, KS 67207.

Notice of Privacy Practices Summary/Acknowledgement

Family Medicine East, Chartered
1709 S. Rock Road
Wichita, Kansas 67207

Maintaining privacy of your health information is very important to us. You will receive a copy of our *Notice of Privacy Practices*. The following is a brief summary of the content of the notice. We encourage you to read the entire notice and ask any questions you may have regarding its contents.

How we may use and disclose health information about you. This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. These types of uses and disclosures are specifically permitted by law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

Your rights regarding your health information. This section describes the rights you have with respect to your health information and tells you how you may exercise these rights. There is also a description of your rights regarding the Health Information Exchange.

How to file complaints concerning our privacy practices. This section tells you what you can do it you believe any of your rights have been violated. You will not be penalized for filing a complaint.

We ask you acknowledge your receipt of this notice by signing below. You should keep the copy of the notice, however if you wish to receive another copy you may request a copy at any time. Also, the most current copy of our notice will he posted in our office. If there are material changes to this notice at a later date, they will be posted in our office and on our website, or you may request a copy at any time.

I acknowledge that I received a copy of my provider's Notice of Privacy Practices with the effective date of March 1, 2017.

Printed Patient Name	Patient's Date of Birth
Signature of Patient/Patient Representative	Date
Relationship to Patient	

STANDING CONSENT TO ACCESS EXTERNAL PRESCIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL THE FOLLOWING

I, _____, whose signature appears below, authorize Family Medicine East and its affiliated providers to view the external prescription history via the RXHub service for the patient listed below.

Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

_____
Patient Name

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

_____ _____ _____
Signature of Patient or Guardian Date If Guardian, Relationship to Patient