



Trinity Medical Associates

New Patient Registration Form

Patient Name: Last _____ First _____ M.I. _____

Email Address _____

Home Address _____

City _____ State _____ Zip Code _____

Date of Birth ____/____/____ Sex: Male Female

SSN _____ - _____ - _____

Home Phone () _____ - _____ Cell Phone () _____ - _____

Work Phone () _____ - _____ The Best Number to reach me is: Home Cell Work

Preferred Language: English Spanish Other _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Prefer not to answer

Race: (Check all that apply) Caucasian/White African American/Black Hispanic/Latino

Native American/Eskimo Asian/Pacific Islander Other _____ Prefer not to answer

Pharmacy Name _____ Pharmacy Phone Number _____

Emergency Contact:

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Relationship to the Patient: _____

Is it ok to discuss your care this person? yes no

Who else can we talk to about your care?

Name: _____

Relationship: _____ Phone Number: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient Signature: _____

Date: _____



Trinity Medical Associates

Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending Physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent be continuing in nature even after a specific diagnosis has been made and treatment is recommended. The consent will remain in full force until revoked in writing.

I, the undersigned authorized Trinity Medical Associates to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Trinity Medical Associates.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or responsible party) Signature

Date



Trinity Medical Associates

Office Financial Policy

Thank you for choosing us as your healthcare provider. TMA is committed to your care. Please understand that payment of your bill is considered part of your care. The following is a statement of our financial policy, which we require you to read and sign prior to seeing the doctor.

How may I pay?

Payments can be made by cash, money order, check, or credit card. A returned check fee in the amount of \$35 dollars may be assessed to your account for every check returned for insufficient funds, stopped payment, or a closed check.

What is my responsibility for my insurance plan's requirements?

Our staff interacts with many insurance companies, each with different plans, rules, and regulations. Although we will do our best to assist with your insurance company's requirements, it is the patient's responsibility to ensure that all required permissions are obtained including referral, pre-certification, pre-authorization, and using in-network facilities. You will be responsible for the entire bill if payment is denied by the insurance company for failure to obtain the requirements.

Insurance and Personal Information

It is the patient's responsibility to ensure we have the most current and updated information possible. You must bring your current insurance card with you to each visit and notify us of any changes in address, phone number, or marital status.

Co-payments

TMA is contracted with most insurance providers and is contractually required to collect ALL co-pays prior to service. Please be prepared to pay the copay at each visit.

Self-pay Patients

If you do not have health insurance, payment in full is expected at the time of service.

Motor Vehicle Accidents & Workers Compensation Cases

We are pleased to see our long-term patients for motor vehicle accidents. However, to meet legal requirements, we must have full insurance details along with the claim number and claim address. If these are not available, then your visit may be regarded as a self-pay appointment. We cannot bill private medical insurance for these claims. We do not accept Workers Compensation cases.

Missed Appointments

Missed appointments put a tremendous financial burden on our office. Because of this, we require at least 24hrs notice for cancellation of appointments. You may be charged a \$95.00 fee for not showing up for an appointment without giving 24hrs notice. If two consecutive appointments are missed, Trinity will not fill any medications until you are seen in the office for an appointment.

Medicare

Our physicians have agreed to accept Medicare's assignment on all Medicare claims. Accepting assignments means that we must accept Medicare's approved amounts. However, Medicare only pays a portion (generally 80%) of the approved amount above your deductible. In addition to your deductible, you are responsible for the other portion (generally 20%) of the approved amount. Many patients have supplemental insurance to cover the portion that Medicare does not. You will be billed for any allowable balance not covered by Medicare and/or your supplemental insurance plan.

Signed _____ Print _____

Date _____



Trinity Medical Associates

Prescription Refill Policy

Medications: We strive to have zero errors related to your prescriptions & medications. Therefore, please bring all prescription bottles or a list of medications to each appointment.

Please read the following prescription refill policy carefully and sign below:

- I will make every effort to have medications filled at the time of my office visit
- I agree to allow 72 hours for prescription refill requests to be processed unless it is a controlled substance, which could take up to 7 days to fill. Controlled substances should be filled at time of visit. (see controlled substance policy)
- I will use the refill request line to leave a voicemail message unless I require an urgent refill; in which case I will ask to speak to a team member
- I understand that refills should be requested Mon-Thurs; and that refills requested after 4:00 pm on Thursday may not be received until Monday
- I understand that a follow-up visit may be required in order to refill my medication
- I understand that for safety reasons the office does not accept auto-refill requests from pharmacies, as the doses/medications are often incorrect
- I agree to take all medications as instructed; and will not alter or change the dosage without consulting a medical provider first
- I will keep all follow up appointments as recommended so that my medications and any relevant lab work can be monitored
- I will not alter or forge a prescription; this is a felony and will be reported
- I understand that any and all controlled substances require a face to face office visit with the provider
- I will not trade, sell or give away my medication
- I will not drive while taking any narcotic or controlled substance
- I will not combine alcohol with any narcotic or controlled substance
- I understand only emergency medications will be called in after-hours
- I understand controlled substance will not be called in or refilled after hours or without an office visit

Pharmacy: _____ Date: _____

Patient Name: _____ SIGNATURE: _____



Trinity Medical Associates

Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of Trinity Medical Associates, PA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how Trinity Medical Associates may use and disclose my confidential information.

I understand that Trinity Medical Associates, PA reserves the right to change their privacy practices that are described in the notice. I also understand that a copy of any revised notice will be made available upon request.

Signature _____

Print _____

Date _____

If you are not the patient, please specify your name and relationship to the patient:
