Family Center
VitaleHEALTH

Registration Form

*Please print legibly and completely

PATIENT INFORMATION				
Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	
Preferred name:	Email Address: @		Marital status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed	
Date of Birth: / /	Age:	Social Security no.: - -	Primary phone no.: ( ) - Secondary phone no.: ( ) -	
Street address:		City, State, ZIP code:		
Mailing address: ❑ (check if same as above)				
Occupation:	Employer:	Employer phone no.: ( ) -		
Referred to clinic by: ❑ Dr. _____ ❑ Drive By ❑ Insurance Plan ❑Hospital ❑ Family/Friend ❑ Close to home/work ❑ Other_____				

INSURANCE INFORMATION				
Insurance Name/Plan Type:		❑ I am Self-Pay (No Insurance)		
Policy ID no.:	Group no.:	Insurance Phone no.: ( ) -		
Relationship to primary carrier: ❑ Self ❑ Spouse ❑ Child ❑ Other_____	Subscriber's Name:	Subscriber's Sex: ❑Male ❑Female		
Subscriber's Date of Birth: / /	Subscriber's SSN No.: - -	Subscriber's Phone no.: ( ) -		
Subscriber's Address: ❑ check if same as patient's address				
SECONDARY INSURANCE INFORMATION (if applicable)				
Insurance Name:	Relationship to primary subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other_____			
Policy ID no.:	Group No.:	Insurance Phone no.: ( ) -		
Subscriber's Name:	Subscriber's Sex: ❑Male ❑Female	Subscriber's SSN No.: - -		
Subscriber's Phone No.: ( ) -	Subscriber's Address: ❑ check if same as patient's address			

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 Family Center VitaleHEALTH or insurance company to release any information required to process my claim(s).

_____ _____ _____/_____/_____

Signature Print name (if other than patient) Date

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Authorization for Disclosure of Protected Health Information

Patient Name:	Date of Birth: / /	Phone No.: ( ) -
Patient Address:		Patient SSN: - -

Family Center VitaleHEALTH is authorized to receive medical record from:

Name of Facility/Physician:	Phone No.: ( ) -	Fax No.: ( ) -
Address:		

Information to be disclosed:
Date Range(s):_____

❑ **All health information**	❑ Billing Information	❑ Lab Results
❑ Physician's Orders	❑ Past/Present Medications	❑ Consultation Reports
❑ Progress Notes	❑ Operation Reports	❑ Discharge Summary
❑ Pathology Report	❑ Diagnostic Test Reports	❑ EKG/Cardio Reports
❑ History/Physical Exam	❑ Radiology Reports/Images	❑ Other_____

Please initial specific areas to release sensitive information:

___ Mental Health Records
___ HIV/AIDS Test Results/Treatment
___ Drug, Alcohol or Substance Records
___ Neurology Records

For the purpose of:

❑ Continued Care	❑ Personal Use	❑Attorney/Legal
❑ Insurance	❑ Billing/Claims	❑ School/Employment
❑ Other:_____		

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to person(s) or entity listed above.

_____ Signature

_____ Print name (if other than patient)

____/____/____ Date

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Medication List

Patient Name:_____ Date of Birth:____/____/____

	Medication Name	Dosage	Frequency	Reason
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

*__Allergies__ (food or medication) and __reactions__:

_____

Pharmacy Information		
Pharmacy Name:	Pharmacy Phone No.: ( ) -	Pharmacy Fax No.: ( ) -
Pharmacy Address:		❑ I would like written/paper prescriptions

In Case of Emergency		
Name:	Phone No.: ( ) -	Relationship:
Name:	Phone No.: ( ) -	Relationship:

I give consent to Family Center VitaleHEALTH to contact person above in reference to any item that assist the practice in carrying out, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

_____ _____ ____/____/____

Signature Print name (if other than patient) Date

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HIPAA Information and Consent Form

Patient Name:_____ Date of Birth:____/____/____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal or providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers a sis necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedure utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications information you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing below, I do hereby consent and acknowledge my agreement to these terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____	_____	____/____/____
Signature	Print name (if other than patient)	Date

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General Consent for Care and Treatment

Patient Name:_____ Date of Birth:____/____/____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has ben recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purposed, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant or clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedure are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

_____	_____	____/____/____
Signature	Print name (if other than patient)	Date

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Assignment of Benefits Agreement

Patient Name:_____ Date of Birth:____/____/____

Family Center VitaleHEALTH will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your insurance benefits is between you and your insurance company. The obligation you have with our practice is to pay for treatment regardless of the amount that my or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- All managed care co-payment and/or deductible and co-insurance amounts are due at the of time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at the time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECLTY TO THE DOCTOR.

_____	_____	____/____/____
Signature	Print name (if other than patient)	Date