

# PATIENT REGISTRATION FORM

\*\*Today's Date: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

## PATIENT INFORMATION: (Please use full legal name, no nicknames)

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

\*Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emerg Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please tell us how you heard about us:

Referred by \_\_\_\_\_

## GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

\*Relationship of Guarantor to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

\*Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

*IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*

### PRIMARY INSURANCE:

Plan Name : \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_

\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

### SECONDARY INSURANCE:

Plan Name : \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_

\*Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_

\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ \* Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

\*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.

\*ATTACH COPY OF INSURANCE CARDS.

*Please read and sign back of form.*



**FINANCIAL RESPONSIBILITY AGREEMENT**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date of Visit:** \_\_\_\_\_

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(please sign here – Patient or Responsible Party)*

**Responsible Party Name:** \_\_\_\_\_  
*(please print name of Responsibility Party if different from Patient)*



## HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

### **Uses and Disclosures**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations.** Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement.** Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

### **Research**

Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### **Additional Uses of Information**

**Appointment Reminders.** Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- ♦ The right to request restrictions on the use and disclosure of your protected health information;

## HIPAA Notice of Privacy Practices

- ♦ The right to receive confidential communications concerning your medical condition and treatment;
- ♦ The right to inspect and copy your protected health information;
- ♦ The right to amend or submit corrections to your protected health information;
- ♦ The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- ♦ The right to receive a printed copy of this notice.

### **Practice Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer  
MedicalEdge Healthcare Group  
9229 LBJ Freeway  
Dallas, TX 75243  
(972) 792-3803

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.



**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices**

This Clinic reserves the right to modify the privacies outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)	Date of Birth
Signature of Patient	Date of Signature
Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)	Relationship to Patient

**Request for Confidential Communication of Your Protected Health Information**

Please circle your response to the following

- May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A
- May we leave **messages** on a voice mail at work? Yes No N/A
- May we discuss you **appointment/treatment** with your spouse? Yes No N/A
- If you are over the age of 18, still living at home, may we discuss your **appointments/treatments** with your parent(s) or guardian? Yes No N/A
- If you are over the age of 18, may we discuss your **appointment and /or treatments** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in patient's medical record.

Benchmark Family Medicine  
5501 Gordon Smith #500  
Rowlett, TX 75088

## DISCLOSURE REGARDING ANCILLARY SERVICES/RESEARCH PROGRAMS

### Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service that is provided by a third party relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging	Bone Density Imaging
Mammography	Nuclear Lab
Ultrasound	Laboratory
Computer Tomography	Computer Tomography
Angiography	
Vascular Laboratory	Echo
Positron Emission Tomography	Sleep Therapy
X-Ray	

In addition, providing Durable Medical Equipment (such as wheel chairs) and Infusion Drug services are Ancillary Services.

Your physician may have an economic interest in or other business relationship with the company or other person to whom the physician refers you to obtain an Ancillary Service. You are not obligated to use the person to whom your physician refers you for an Ancillary Service. You are free to use any person you choose to provide you with an Ancillary Service.

### Research Programs

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. Your physician may be compensated for services rendered in connection with the research program or another research program. You are not obligated to participate in any research program and we will obtain your permission prior to your participating in a program your physician believes may be appropriate for you.

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

\_\_\_\_\_, 200

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Name

