Clark Physician Group

A Norton and LifePoint Partnership

Today's Date ____/____/_____ # PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one)	City	State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address (To be used for appointment reminders)			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy: Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number
			( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO **Insurance Name**

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

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Date: _____

FAMILY AND PERSONAL HEALTH HISTORY

Patient's Full Name: _____ DOB: _____

Pharmacy Name/Address: _____

Previous Primary Care Physician: _____ Referred by: _____

Have you been seen in our office before: Yes No

OTHER PHYSICIANS THAT PARTICIPATE IN YOUR HEALTHCARE:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATION/SUBSTANCE ALLERGIES: (Please list reactions)

1. _____
2. _____
3. _____

MEDICATIONS: (Please list name, dose, and frequency)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ADVANCED DIRECTIVES:

Do you have a Living Will? (Please provide copy) [ ] Yes [ ] No

Do you have a Power of Attorney? (Please provide copy) [ ] Yes [ ] No

What is your Code Status? (Example: DNR- Do Not Resuscitate) _____

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Alcohol Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Tobacco Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Illicit Drug Use: [ ] None [ ] Marijuana [ ] Cocaine [ ] Crack [ ] Meth [ ] Other _____

Caffeine Use: [ ] Soda [ ] Coffee [ ] Tea # per day_____

Do you exercise regularly: [ ] Yes [ ] No How many times per week? _____ How long? _____

Activities:_____

Religion: _____

Occupation:_____

With whom do you live?_____

Patient's Name: _____

DOB: _____

PERSONAL HISTORY:

[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Heart Attack
[ ] Yes [ ] No Heart Disease
[ ] Yes [ ] No High Blood Pressure
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Depression, Anxiety, Bi-Polar
[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Cancer (Type) _____
[ ] Yes [ ] No Other _____

# of Pregancies ____ # of Live Births ____ Miscarriages ____ Abortions ____

C-Sections (# and Year) _____

PREVENTIVE HEALTH: (Please list dates and results)

Cholesterol _____ Dexa Scan _____

Mammogram _____ Pap Smear _____

Colonoscopy _____ PSA _____

IMMUNIZATIONS: (Please list dates)

Pneumonia _____ Hepatitis A _____

Tetanus _____ Hepatitis B _____

Measles _____ Tuberculosis _____

Influenza _____ Shingles _____

Other _____ Other _____

FAMILY HISTORY: (Please check all that apply)

Illness/Condition	Father	Mother	Sibling	Grandparents (Maternal/Paternal)
Diabetes				
Heart Attack				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Disease				
Depression/Anxiety/Bi-Polar				
Stroke				
Osteoporosis				
Cancer				
Other				

RECENT HOSPITALIZATIONS: (Year, Illness, Surgeries)

1. _____
2. _____
3. _____
4. _____
5. _____

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HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may ***talk*** to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

_____

_____

I acknowledge receipt of the Notice of Privacy Practices.

_____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient (if other than patient) _____

☐Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness _____
Printed Name- Practice Representative

Witness _____ _____
Signature Date

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Clark Physician Group. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Clark Physician Group. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

8. **ADVANCE DIRECTIVE:** ❑ I have executed an Advance Directive ❑ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent