Today's Date _/ /

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last **First** **Middle**

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)		- -	

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:

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?
☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE _☐ WORKERS COMPENSATION (WC)

Does the patient have healthcare coverage? ☐ YES ☐ NO — Name of Insurance Company

Name of Subscriber	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 Company	Name of Subscriber	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/Parent/Guardian Signature Date

Demographic Supplement

Patient Name: ____ DOB: _____________

Child lives with: ____

Child attends school at: ____

Father: _____________________________ Mother: _____________________________

SS#: _______________________________ SS#: _______________________________

DOB: _______________________________ DOB: _______________________________

Employer: ___________________________ Employer: ___________________________

Work Phone: _________________________ Maiden Name: _________________________

May we call you at work: ______________ Work Phone: _________________________

May we call you at work: _______________

We realize that Parents or Legal Guardians may not always be able to personally bring their child to the office themselves. However, Indiana Law dictates that a patient under the age of 18 cannot be treated without a parent or legal guardian present. If a parent of legal guardian cannot be present, then anyone authorized below can accompany the child and give consent for treatment. This form MUST be completed by a parent or legal guardian.

I, ____, the parent or legal guardian of

____, give consent for the following people to have
(child's name)

my child treated by providers and staff at Jeffersonville Pediatrics:

Authorized People	**Relationship to Patient**
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

Signature: _____________________________________ Date: _____________________

Clark Physician Group

A Norton and LifePoint Partnership

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

10/2014

Clark Physician Group

A Norton and LifePoint Partnership

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

Clark Memorial Hospital

A Norton and LifePoint Partnership

❑ Account # ____________________
❑ MR # ____________________

AUTHORIZATION FOR RELEASE OF INFORMATION

(Name of Patient) _______ (Date of Birth) _______ Daytime Phone _______

(Address) _______ (City) _______ (State) _______ (Zip) _______

Dates of Treatment or Service: ____________________

I authorize Dr. ____________ ,Clark Physician Group, to **DISCLOSE** information specified below to:

Name: ____________________

Address: ____________________

City/State: ____________________

Phone: ____________________

Fax: ____________________

I authorize Dr. ____________ ,Clark Physician Group, to **OBTAIN** information from:

Name: ____________________

Address: ____________________

City/State: ____________________

Phone: ____________________

Fax: ____________________

Information to be Disclosed

_________Diagnosis/Dates of Treatment
_________Discharge Summary (includes diagnosis, history, results of treatment, prognosis)
_________History and Physical
_________Emergency Room Records
_________Entire Record
_________Consultation
_________Other, explain: ____________________

_________Operative Report
_________HIV (AIDS or AIDS related information)
_________Lab Results (Specified Date or All) ____________
_________(X-rays, EEG, EKG, etc.)
_________Psychological/Psychiatric Evaluation
_________Pathology
_________Letter confirming attendance/treatment

Purpose or Need For the Disclosure: ❑ Physician / Hospital - Continuity of Care ❑ Personal Use ❑ Legal ❑ Disability

❑ Other, Explain: ____________________

❑ Electronic copy of my health information. I understand that I will be given a flash/USB/thumb drive and it is my responsibility to secure the information and it is no longer the property of Clark Memorial Hospital or Clark Physician Group.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____________. If I fail an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that if I have been treated for drug or Alcohol abuse my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date: ____________ *Signature of Patient or Legal Guardian ____________

Witness: ____________ Relationship to Patient ____________

❑ CPG has permission to fax my Health Information to: ____________ Fax #

ID Verification No.: ____________

Copied By: ____________

Date Released: ____________

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S/M CONSENTS

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