

Patient Registration Form
Family Medical Group

Select One: Thomas Wilson M.D. James MacLaren M.D.
Scott Hennes M.D. James Knapp M.D.

Patient's Personal Information

Marital Status: Single // Married // Divorced // Widowed

Name: _____
Last name first name initial

Date Of Birth: ____/____/____ Sex: Male // Female Social Security #: ____/____/____

Home Phone: (____) _____ Work # (____) _____ Cell # (____) _____

Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Mailing Address (if Different) _____

Patient's Responsible Party Information

Relationship to Patient: self / spouse / parent /

Name: _____
Last name first name initial

Date Of Birth: ____/____/____ Sex: Male // Female Social Security #: ____/____/____

Home phone#: (____) _____ Work# (____) _____ Cell# (____) _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Patient's Insurance Information

please present insurance cards to receptionist

PRIMARY Insurance Name: _____

Address: _____ City _____ State _____ Zip _____

Name of policyholder: _____ Date of Birth: _____

Address of policyholder (if different) _____

Social Security # _____ Relationship to Patient: Self parent spouse other

Id# _____ Group # _____ Copay: \$ _____

SECONDARY Insurance Name: _____

Address: _____ City _____ State _____ Zip _____

Name of policyholder: _____ Date of Birth _____

Address of policyholder (if different) _____

Social Security # _____ Relationship to Patient: Self parent spouse other

Id# _____ Group # _____ Copay: \$ _____

Emergency Contact*(Person not living with you)**

Name: _____ Relationship _____

Address: _____ City: _____ State: _____

Home Phone: (____) _____ Work #: (____) _____ Cell# (____) _____

Other family members in your household

First name	last name	birthdate	relationship

Pharmacy Information

Name of Pharmacy: _____

Address: _____ City _____ State: _____

Phone: (____) _____ Fax: (____) _____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Family Medical Group and any Assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I agree to pay \$25.00 service charges for any appointment (\$45.00 for a complete physical or procedure appointment) not cancelled at least 24 hours in advance of my scheduled appointment time. I understand that repeated missed appointments may result in my dismissal and that of my immediate family members from the practice. I agree to pay \$25.00 for any returned check. Forms requiring completion by the provider, such as disability and work release forms, require a \$15.00 fee. Triplicate prescriptions also require a minimal fee of \$10.00 per prescription. Patients with no insurance coverage are responsible for payment at the time of service. Copayments are also payable at the time of service. We accept cash, credit cards, ATM and checks.

Responsible Party Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how our medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request your information be restricted;
4. The right to request confidential communications;
5. The right to a reporting of disclosures of your information;
and
6. the right to a paper copy of this notice.

We want to assure you that your medical information is secure with us. This Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received this practice's *Notice of Privacy Practices*. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed in the Notice. I further understand that the practice will offer me updates to this *Notice of Privacy Practices* should it be amended, modified or changed in any way.

Printed Name of Patient or Patient Rep

Signature

Date

Patient Refused to sign

Patient was unable to sign because of _____

PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by Family Medical Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations at Family Medical Group. I understand that diagnosis or treatment of me at Family Medical Group may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Medical Group is not required to agree to the restrictions that I may request. However, if Family Medical Group agrees to the restrictions that I may request, the restriction is binding on Family Medical Group and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that Family Medical Group or its providers has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

I give my permission for _____ (print name and relationship to patient) to obtain information regarding my protected health care information, including, but not limited to, laboratory test results, specialty referrals and referral results, other testing or procedures as initiated by my Family Medical Group provider.

I understand I have the right to review Family Medical Group's Notice of Privacy Practices prior to signing this document. Family Medical Group's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Family Medical Group. The Notice of Privacy Practices for Family Medical Group is also provided in the waiting room and at the receptionist desk and on the practice's website (www.fmgturlock.com). This Notice of Privacy Practices also describes my rights and the Family Medical Group's duties with respect to my protected health information.

Family Medical Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, contacting the office to request a revised copy be sent by mail or asking for one at my next appointment.

Signature of Patient or Patient Representative

Date

Printed Name of Patient /Patient Representative

Description of Representative's Authority