Primary Care of Cedar Hill-Imperial

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: ____________________ How did you hear about us?:________________________________

Name: (Last, First, Middle)____

Name you prefer to go by:______________________________ Birth/Maiden Name:__________________________

Date of Birth: __________________ Age: _______ Social Security #: ___________________________

Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ Declined ☐ Amer. Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other

Ethnic Group: ☐ Declined ☐ American ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Language: ☐ English ☐ Other

Address: ____ City:_________________________________

State: __________ Zip: _______________ Home Phone: ______________________ Work: ______________________

Cell Phone: _________________________ Email Address: ____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Driver's License Number: ____ Driver's License State: ________________

Employer Name and Address: ____________________________________ Occupation: ________________________

RESPONSIBLE PARTY INFORMATION – Note if you are over the age of 18 yrs. You are responsible for yourself.

Name of Responsible Person: ____ Date of Birth:____________________

Relationship to patient: ☐ Self ☐ Child ☐ Spouse ☐ Other

Address: ____ City:___________________________________

State: ____________ Zip: ______________ Home Phone: ____________________ Cell Phone: __________________

Employer Name and Address: _____________________________________ Occupation: ________________________

Continuation: PATIENT INFORMATION

Are you an Organ Donor: ☐ Yes ☐ No Do you have a Living Will? : ☐ Yes ☐ No ☐ Unknown

Do you have an Advanced Directive? ☐ Yes ☐ No ☐ Unknown

Would you like to receive additional information about Advanced Directives? ☐ Yes ☐ No

What is your most Commonly Used Pharmacy: ____________________ Where? ____________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____________________ Relationship to patient: ____________________

Home: ____________________ Cell: ____________________ Work: ____________________

(PRIMARY) INSURANCE INFORMATION

Name of Insurance: ____________________ ID # ____________________ Group # ____________________

Name of Primary Policy Holder: ____________________ Date of Birth: ____________________

Relationship to the Patient: ____________________

(SECONDARY) INSURANCE INFORMATION

Name of Insurance: ____________________ ID # ____________________ Group # ____________________

Name of Primary Policy Holder: ____________________ Date of Birth: ____________________

Relationship to the Patient: ____________________

____________________ ____________________

Signature Date

____________________ ____________________

Parent (if minor) Date

Primary Care of Cedar Hill-Imperial

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: ______________________________ Date of Birth: ____________________

Signature: ______________________________ Date:____________________________

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: ___________________________________ Relationship to Patient: ______________

Signature: ______________________________ Date:____________________________

Medical Record Release Authorization

Primary Care of Cedar Hill-Imperial
1501 Professional Dr.
Imperial, MO 63052
Tel: (636)464-4000
Fax: (636)529-0699

Other Locations:
Primary Care of Cedar Hill
Tel: (636) 274-2700 Fax: (636)529-0699
Primary Care of Cedar Hill-Pacific
Tel: (636)271-3500 Fax: (636)529-0699

Patient Name______________________________ **Maiden Name**______________ **SS#**__________

Date of Birth______________ **Home Phone**__________________ **Cell/Work**__________________

Address____ **City/State/Zip**______________________

Email Address: ____

B) To be released TO:

Name______________________________
Address____________________________
City/State/Zip_______________________
Phone#_____________ Fax#_____________

A) I hereby authorize records FROM:

Name______________________________
Address____________________________
City/State/Zip_______________________
Phone#_____________ FAX#_____________

C) For the purpose of:

_____ Litigation _____ Disability

_____ Insurance _____ Work Comp

_____ Self/Personal Copy _____ Other

_____ Transfer or Continuity of Care

Date Range_______________ to_______________

☐ Physician Office Notes ☐ Cardiology/EKG Reports
☐ Immunizations ☐ Lab/Path Reports
☐ Operative/Procedure Reports ☐ Other ___________
☐ Radiology/XRay/MRI Reports ☐ Minimum Necessary

Medical Record Release Authorization

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that 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. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_______________ ______________________________ **Subject to Fees
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: ____________________
(Expiration date of authorization)

***PLEASE READ** Fee Information*:* **Primary Care of Cedar Hill-Imperial** contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.
DataFile Technologies: 816-437-9134 www.datafiletechnologies.com

Primary Care of Cedar Hill-Imperial Financial Policy and Authorizations

We are happy that you selected Primary Care of Cedar Hill-Imperial for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

________________________________ _______________

Patient or Parent/Guardian if Minor Date

Primary Care of Cedar Hill- Imperial
1501 Professional Drive, Imperial, MO 63052
Phone: 636-464-4000 Fax: 636-529-0699

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information. amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

______________________	______________________
Name of Patient	Signature of Patient/Date Signed
______________________	______________________
Name Patient's Personal Representative	Signature of Patient's Personal Representative/ Date Signed

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FOR INTERNAL USE ONLY

______________________	______________________
Name of Employee	Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained: D

- ○ Patient was unable to sign.
- ○ Patient refused to sign.
- ○ Other:

Version 1 Effective Date: 2/1/2018

Notice of Privacy Practices (NPP) Acknowledgement

Insert additional Patient Information as needed.

Primary Care of Cedar Hill- Imperial
1501 Professional Drive, Imperial, MO 63052
Phone: 636-464-4000 Fax: 636-529-0699

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Patterson Family Practice to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
CELL PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
WORK PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
ALTERNATE PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
PATIENT PORTAL & SECURE EMAIL	❒1 ❒2 ❒3 ❒4 ❒5	EMAIL ADDRESS:	
☐ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Primary Care of Cedar Hill- Imperial to disclose your PHI to the following individuals (check all that apply):

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (________)________________ **Email:** ______________________________
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: __________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: __________

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (________)________________ **Email:** ______________________________
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: __________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: __________

Name: ______________________________ **Relationship to Patient:** ______________
Telephone: (________)________________ **Email:** ______________________________
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: __________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: __________

☐ **None of the above** **Signature/Date:** ______________________________

Created: 09/23/13, revised 2/13/15, revised 10/1/2015, revised 1/18/2018