Square One Family Medicine

Patient Registration Form

Patient's Name: (Last)_____(First)_____(MI)_____

Adress:_____

City:_____ State:_____ Zip:_____

Home:_____Cell:_____Work:_____

E-Mail Address:_____D.O.B:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex: ☐ Female ☐ Male ☐ Transgender

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

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number:_____

Responsible Party Information (If not Self)

Responsible party name: (Last)_____(First)_____(MI)_____

Date of birth: _____ Sex: ☐ Female ☐ Male Social Security: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____(First)_____

Phone number:_____

Emergency contact relationship to patient:_____

Address:_____

City: _____ State:_____ZIP:_____

Home phone:_____Work:_____Home:_____

General Consent for Care and Treatment consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical. medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards Involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (I) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____

Printed name of patient or personal representative:_____

Date: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, Square One Family Medicine may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Square One Family Medicine may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Square One Family Medicine any insurance or other third-party benefits available for health care services provided to me. I understand Square One Family Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Square One Family Medicine I agree to forward all health Insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. request payment of authorized benefits to be made on my behalf to Square One family Medicine by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, for Square One Family Medicine or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that Square One Family Medicine or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Square One Family Medicine or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre- recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/Representative signature:_____ Date:_____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list

- Spouse
- Parent
- Legal Guardian
- Guarantor
- Healthcare Power of Attorney
- Other (please specify)

Patient HIPAA Acknowledgment and Consent Form

Notice of Privacy Practice/clinics

_____(Patient/Representative initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email, Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Late Arrivals, Cancelations and No-Shows

- **Late Arrivals**: If you arrive late for a schedule appointment you may be asked to reschedule your appointment or wait for an open appointment available.
- **Cancellations**: If you are unable to keep your appointment, you must call at least one business day in advance, or we may consider you a "No-show"
- **No-Shows**: If you miss your appointment, you will be charged a $25 fee which will need to be paid by your next appointment.

If permitted by state law, you may be discharged as a patient following three no-shows in one year.

Signature: _____ Date: _____

Patient HIPAA Acknowledgment and Consent Form

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and ADS.

I certify that have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature: _____ Date: _____

Patient Responsibility

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in.

If you have an Annual Wellness Visit or Physical Exam but need or request additional services, we may bill you for those additional services except United Healthcare we will only do a Physical Exam or an office visit at a time. All services for patients who are minors will be billed to the custodial parent or legal guardian.

Types of Payments

1. Co-payment: Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to make your co-payment, you may reschedule your appointment.
2. Deductibles: Most insurance plans require you to pay a predetermined amount before your insurance will cover certain charges. For new patients who have not met their deductible, we may collect up to $169; for establish patients we may collect up to $110. When your insurance completes processing the claim, you may be responsible for an additional amount depending on our contract with your insurer.
3. Co-insurance: Some insurance plans require that you pay a certain percentage of the allowable charge amount. Our technology allows us to view the details of your insurance plan, including your co-insurance amount, and calculate the expected out of pocket for you due on the date of the visit
4. Self-pay: If you do not have insurance or if the services provided are not covered by your insurance, payment for all services are due at the day of the visit.

Insurance

We ask all patients to provide their insurance card and proof of identification at their first initial visit. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology, or other diagnostic related providers.

Outstanding Balances:

After your visit we will send you a statement for any outstanding balances. We usually send out statements every 28 days, beginning when the balance becomes the patient's responsibility.

You are responsible to:

- Know if a referral or authorization is necessary for office visits.
- Check with your insurance plan to determine if testing (labs, radiology, ect.) is covered under your insurance plan.
- Check with your insurance plan to review the schedule of benefits and weather a co-payment or deductible applies.
- Coordinate benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary.
- Arrive to appointments with all require documentation

Square One Family Medicine

Name: _____ Date of Birth:_____Height:_____

Reason for Visit today:_____

Are you allergic to any medications: Yes or No

Allergic to the following medications	Type of Allergic reaction

List the name and dosage of the medication you are currently taking:

Current Medications	Dosage

Pharmacy Information:

Name:_____Phone Number:_____

Address:_____

Please circle your past medical History:

Allergies	Blood clots	Depression	High Blood Pressure
Anemia	Cancer	Diabetes	Irritable bowel syndrome
Anxiety	CVA (stroke)	Gallbladder disease	Liver disease
Arthritis	COPD	Gerd (reflux)	Migraine Headaches
Asthma	CAD (heart disease)	ADHD	Heart attack
Atrial Fibrillation	Crohn's disease	High Cholesterol	Renal Disease(kidneys)
AIDS/HIV	Seizure disorder	Thyroid disease	Osteoporosis

Surgeries: Indicate the date/year if known:

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

Please list any additional medical history or surgical history:

_____

Please provide your family medical history:

Father:_____

Mother:_____

Sister:_____

Brother:_____

Other:_____

Social History

Do you Smoke? Yes No Former: Year quit:_____

Do you drink alcohol? Yes No Former: Year quit:_____