

Patient Registration Form

Patient Information

Legal Name _____
Other/Previous Names Used _____
Address _____
City _____ St _____ Zip _____
Telephone (H) _____ (C) _____ (W) _____
OK to Leave Message on ___(H)___(C)___(W) OK to Discuss Billing Info on Cell Phone: Y / N (Circle)
Birthdate ___/___/___ SS# ___-___-___ Sex: M / F (Circle) Advance Directive: Y / N (Circle)
Email _____ Interested in Patient Portal: Y / N (Circle)
Race _____ Language: ___English___Spanish___Other _____
Marital Status _____ Occupation _____
Employer _____ Address _____

Responsible Party If Other Than Self

Name _____ SS# ___-___-___ DOB ___/___/___
Address _____ City _____ St _____ Zip _____
Relationship to Patient _____ Employer _____
Telephone (H) _____ (C) _____ (W) _____

Primary Insurance

Ins Company _____
Insured Birthdate (Required) ___/___/___ SS# ___-___-___
Relationship to Patient _____ Family Policy Y/N (Circle)

Secondary Insurance

Ins Company _____
Insured Birthdate (Required) ___/___/___ SS# ___-___-___
Relationship to Patient _____ Family Policy Y/N (Circle)

Emergency Notification/Next of Kin/Not Living with You

Name _____ DOB ___/___/___
Address _____ City _____ St _____ Zip _____
Relationship to Patient _____ Employer _____
Telephone (H) _____ (C) _____ (W) _____

How Did You Hear About Us? _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S). I AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I GIVE THIS PRACTICE PERMISSION TO TREAT THE ABOVE PATIENT, OR MYSELF.

I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN PLACE OF THE ORIGINAL.

Signed (Patient or Representative)

_____/_____/_____
Month Day Year

**Patient Request for Release of
Protected Health Information**

Family Medicine East, Chartered
1709 S. Rock Road
Wichita, Kansas 67207

Check One:

- I hereby give my permission for Family Medicine East, Chartered to give out protected health information regarding my treatment to the individuals listed below.

- I do not give my permission for Family Medicine East, Chartered to give out protected health information regarding my treatment to anyone other than myself.

Patient Information

Name: _____

Address: _____

Phone: _____

Work Phone: _____

<u>Individuals to Release Information to</u>	<u>Relationship to You</u>	<u>Info to Be Released</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Patient's Signature

Signature of Employee

Date

Authorization valid for 1 year from date of Signature.

Please specify info to be released.
For example:
any/all, billing only, pick-up only, etc.
If left blank, we will assume "any/all"

Notice of Privacy Practices Summary/Acknowledgement

Family Medicine East, Chartered
1709 S. Rock Road
Wichita, Kansas 67207

Maintaining privacy of your health information is very important to us. You will receive a copy of our *Notice of Privacy Practices*. The following is a brief summary of the content of the notice. We encourage you to read the entire notice and ask any questions you may have regarding its contents.

How we may use and disclose health information about you. This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. These types of uses and disclosures are specifically permitted by law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

Your rights regarding your health information. This section describes the rights you have with respect to your health information and tells you how you may exercise these rights. There is also a description of your rights regarding the Health Information Exchange.

How to file complaints concerning our privacy practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing a complaint.

We ask you acknowledge your receipt of this notice by signing below. You should keep the copy of the notice, however if you wish to receive another copy you may request a copy at any time. Also, the most current copy of our notice will be posted in our office. If there are material changes to this notice at a later date, they will be posted in our office and on our website, or you may request a copy at any time.

I acknowledge that I received a copy of my provider's Notice of Privacy Practices with the effective date of March 1, 2017.

Printed Patient Name

Patient's Date of Birth

Signature of Patient/Patient Representative

Date

Relationship to Patient



STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL THE FOLLOWING

I, _____, whose signature appears below, authorize Family Medicine East and its affiliated providers to view the external prescription history via the RXHub service for the patient listed below.

Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

Patient Name

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

Signature of Patient or Guardian Date _____
If Guardian, Relationship to Patient