ROSEU MEDICAL CENTER

Registration Form

Patient Information

Patient First Name			Middle Name		Last Name
Date of Birth	Gender	Race	Social security number		Marital Status
Address			City	State	Zipcode
Cell Phone #			Email address		Work Phone
Pharmacy Name			Pharmacy phone #		Pharmacy Address
Source of referral:			Emergency contact Name:		Emergency contact relationship:
Emergency contact Phone #:			Marital status:		

Billing and Insurance Information

Primary Insurance Name:	Policy #:		Group #:
Insurance phone #:	Insured Name:		Relation to patient:
Insurance Address	City	State	Zip code:
Secondary Insurance Name:	City	State	Zip code:
Secondary Insurance phone #	City	State	Zip code
Motor Vehicle Accident Guarantor's Address	Guarantor's Name	City/state	Zip code
Guarantor's Phone #:			

Reason for Visit

What brings you to the office today:

_____
_____

Allergies : _____

Current Medications:

_____
_____
_____

Past surgery: _____

Last hospital admission date: _____ Reason for admission: _____

Past Medical history (have you ever had any of the following):

□ Asthma

□ Hypertension

□ Diabetes Mellitus

□ Cancer

□ Cardiac disease

Family history (Did anyone in your family have the following) :

Conditions	Yes/No	Family Member if yes:
Heart Disease		
Arthritis		
Diabetes Mellitus		
Blindness		
Glaucoma		
Hypertension		
Cancer		
HIV/AIDS		
Cataract		
Kidney Disease		
Thyroid Disease		
Stoke		
Other:		

Social History:

Do you Smoke ? _____ If yes how many a day: _____

Do you drink alcohol? _____ if yes how much a day: _____

Do you use any recreational drug: _____ if yes name_____

Please list all persons and their relationship to you that we are authorized to discuss your diagnosis, treatment and billing:

Other Information:

Signature of patient/Guardian: _____ Date: _____

*electronic signature serves as acknowledgment

Patient's authorization and assignment of benefits: I hereby authorize the processing of the medical insurance either by electronic or manual method. My signature authorizes payments for all medical benefits to which I am entitled from the insurer(s) that I have provided to the office. Providing my insurance card authorizes the office to use it for my medical bill. I attest that the information that I provided in regards to my insurance company is correct to my knowledge. I recognize my financial obligation of any balance, co-insurance, deductible, and non covered services that may be required.

Appointments: Patients are seen by appointments time, not by arrival time. If you arrive 15 minutes late for your appointment, we may ask you to reschedule your appointment. We appreciate your understanding of our office rules in other to provide quality care to all our patients.

Cancellation Policy: Roseu Medical require all our patients to provide us with at least 24 hours of advance notice before a scheduled appointment. If the patient failed to provide 24 hours notice, the patient will be responsible for $40 fee.

Insurance: If the provided insurance company did not pay for your service, you are responsible for the payment in full. It is your responsibility to make sure your insurance is active and up to date on the date of service.

Co-Payments and Deductibles: When you check-in at the office, you are to pay all your balances, co-pay and deductibles. The arrangement is part of your contract with your insurance company.

Referrals/authorizations: If your insurance requires you to have a prior authorization/referral before medical care, it is your responsibility to obtain it before coming to the office for medical care.

Record Request: To obtain a copy of your medical record, we require a written request from you before copies being made. Allow us at between 10 to 30 days to comply with your request. A fee per page will be charged for the medical record.

Returned Check Fee: You agree to pay $50 for each personal check returned for non-payment by your bank/financial institution.

Patient Billing: We accept cash, checks, credit cards at the office. Any credit balances on a patient account will be applied to any unpaid balances. If you have not met your deductible at the time of your visit to the office, the office will request payment for services rendered on the day. The office will send you balances owe after we receive your explanation of benefit from your insurance, and you are responsible to make the payments. All unpaid balances will be send to collection after 90 days; all fees including, but not limited to, a $100 collection fee and or attorney fee shall become your responsibility in addition to the balance due to the office. If you provide the office with inactive insurance, you will be responsible for the payment. We appreciate your support of our billing policy.

My signature indicates that I have read the above and agreed to the above as stated

Patient/Guardian signature: _____ Date: _____

*electronic signature serves as acknowledgment

Print Name:

_____

*electronic signature serves as acknowledgment

Consent to Treatment: I certify that the information provided is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question o the form or during my care at the office, I should ask the provider or office staff for assistance or clarification. By signing below, I hereby authorize Roseu Medical Center to obtain medication history from community pharmacies for my treatment. I permit Roseu Medical Center to administer an injection, get vital signs, administer vaccination, perform other medical/diagnostic procedures, including blood work, as may be deemed necessary in the diagnosis and treatment of my medical care.

Patient/Guardian signature: _____ Date: _____

*electronic signature serves as acknowledgment

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review:

Our commitment to your Privacy: Roseu Medical values the privacy of your private health information and strives to protect the confidentiality of your medical information. Federal law requires us to issue you an official notice of privacy practices. You have the right to the confidentiality of your medical information and we are required by law to maintain the privacy of your protected health information (PHI). We are required to abide by the terms of the Notice of privacy practices currently in effect. If you have any questions, please contact the privacy officer at the clinic.

Who Will Follow This Notice: Any health care professional authorized to enter information into your medical record and all employees, staff, and other personnel at Roseu Medical Center must abide with this Notice. All subsidiaries, business associates, such as billing services, may share information for treatment, payment purposes, or health care operations described in this Notice.

How we use and disclose information:

Treatment: We may use medical information about you to provide you with medical treatment or services for consultations or referrals to determine the best course of treatment and to communicate between personnel in caring for you.

Payment: You may use your health information to obtain payment from your insurance company such as Name, date of birth, procedure code to identify the treatment rendered, and diagnosis during your visit and or as requested by your insurance company, a copy of your medical record to support payment.

Health Care Operations: We may use and disclose medical information about you for health care operations to ensure you receive quality care to improve our performance or determine how to provide better care and service, to evaluate the clinical efficacy of treatments and to comply with legal requirements, information disclosed to attorneys.

Other potential uses or disclosures that can be made without consent or authorization

• To avert a serious threat to public health or safety

• If required by state, federal or local law

• When required by military command for medical records

• In response to legal processing, such as a subpoena, discovery request or summons

• To report victims of abuse, neglect or domestic violence

• To identify or locate suspects, fugitives witnesses, crime victims or missing persons

• To a coroner or medical examiner for identification of a body

• When required for intelligence, counterintelligence or national security activities, upon request of a government official

• In response to legal proceedings

Acknowledgment AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the current Notice of Privacy for Roseu Medical Center. I have read and understood the information presented in the Notice. I know that I am entitled to request and receive a paper copy of the Notice at any time. I also understand that ROSEU Medical Center has the right to change this Notice at any time. If changes is made to the Notice, I will be provided with a copy of the new Notice at the time of my first visit following the implementation of such changes.

Patient/Guardian signature: _____ Date: _____

*electronic signature serves as acknowledgment