Family Healthcare of Gallatin
Patient Registration Form

First Name: _____ Last Name: _____ M: ____

Date of Birth: ____/_____/____ Social Security #: _____

Gender (please circle one) M F Marital Status (please circle one) S M W D

*Race (please circle one) *Government requires this information to protect patients again discrimination*
American Indian Asian Native Hawaiian African American White Hispanic Other

Address: _____

City: _____ State: _____ Zip code: _____

Best # to reach you: ____-_____-____ Cell phone: ____-____-_____

Home Phone: ____-_____-____

Confidential Email: _____

Employer info:

Employer: _____Work Phone: ____-_____-_____

Employed (please circle one) Full-time Part-time Not Employed Student

Pharmacy info:

Pharmacy Name: _____ Location of pharmacy: _____

How did you hear about us?

_____

_____

Person Responsible for Bill (if different from patient) _____

Relationship: _____ Social Security #: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: ___-____-____ Cell phone _____-_____-____ Work phone: ____-____-____

Primary Insurance Company: _____

Policyholder: _____Social Security #: _____ DOB: ___-___-___

Relationship to patient: _____

Address (if different than above) _____

City: _____ State: _____ Zip code: _____

Policy ID #: _____ Group #: _____ Employer: _____

Secondary Insurance Company: _____

Policyholder: _____ Social Security #: _____ DOB: ____-____-_____

Relationship to patient: _____

Address (if different than above) _____

City: _____ State: _____ Zip code: _____

Policy ID #: _____ Group: _____ Employer: _____

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Family Health Care of Gallatin, PLLC, (b) release of information including protected health information to insurance companies as need to file payments for services incurred, (c) Family Health Care of Gallatin, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to Family Health Care of Gallatin, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) _____ Date: ____-_____-_____

Family Health Care of Gallatin **Release of Information**

Patient Name: _____

I give permission to Family Health Care of Gallatin to discuss my medical condition(s), my treatment, and information regarding my appointments with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

<u>Emergency Contact info:</u>

Emergency Contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____

May we leave a message on your voicemail? YES NO

Consent to Treat

I hereby authorize Family Health Care of Gallatin, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits, and alternatives will be explained at the time of service. I have the right to questions and/or refuse treatment.

_____ _____

Patient Signature Date

Family Health Care of Gallatin
Consent to Disclose Health Care information

It is important for you to know how your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow Family Health Care of Gallatin, PLLC to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. Family Health Care of Gallatin, PLLC has a document called the "Notice of Privacy Practices" that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of Family Health Care of Gallatin, PLLC. A written agreement. The notice is posted in the office of Family Health Care of Gallatin, PLLC may update the "Notice of Privacy Practices" at any time. A copy of the most recent update is available upon request.
3. Under the terms of this consent, I can ask Family Health Care of Gallatin, PLLC to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations.
4. I understand that Family Health Care of Gallatin, PLLC does not have to agree to my request. If Family Health Care of Gallatin, PLLC does agree to my request, I understand that agreed limits would be followed.
5. I understand that I have the right to cancel this consent in writing to the Privacy Officer of Family Health Care Gallatin, PLLC. If I do cancel this consent, I understand that Family Health Care of Gallatin, PLLC may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.
6. I understand that if I cancel this consent, Family Health Care of Gallatin, PLLC does not have to provide further healthcare services to me.
7. I grant Family Health Care of Gallatin, PLLC permission to view my prescription history from external sources.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

I have been given the opportunity to review a current copy of **Family Health Care of Gallatin's Privacy Policy**.

_____ _____

Patient Signature Date

_____

Printed Name

Family Health Care of Gallatin Financial Policy

Thank you for choosing Family Health Care of Gallatin, PLLC.

It is our policy that all fees including co-pays, deductibles, and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filling of insurance does NOT release the patient from responsibility for charges of services which have been provided. Please make sure we have a current copy of your insurance card. **If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not pain withing a reasonable period of time, and for which no special arrangements, have been made, will be subject to placement with collection agencies following due notice.

Have read and understood the above statements, I agree to the terms set forth:

1. I understand my co-pay, deductible, or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to collection agency, I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collect, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for a scheduled appointment, I will receive one courtesy notice. For a second no show appointment, I understand I will receive a bill for the missed appointment. I understand a third missed appointment is grounds for dismissal from the practice.

I, the patient or guarantor/guardian hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will providing subsequent monitoring, care or treatment in connection with care provided by Family Health Care of Gallatin, PLLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to rend medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Family Health Care of Gallatin, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party: _____ Date: _____-_____-_____

Printed Name: _____ Relationship to patient: _____

Almost done…. We need this information to provide the best care:

Please list your current medications. We need the name, dosage, how often it is taken, and who started the medication:

_____

_____

_____

_____

_____

_____

To avoid dangerous interactions, please list any supplements, vitamins, or over the counter products you use regularly:

_____

_____

_____

_____

List any allergies to medications or other:

_____

_____

_____

_____

_____

Last colonoscopy: _____ Doctor that performed: _____
(colon cancer screening)

Last Pap and breast exam: _____

Last Tetanus Booster: _____

Last Pneumonia Vaccine: _____

Please list any Operations or Hospitalizations: _____

_____

_____

Anything else we need to know: _____

_____

_____

PROVIDER PERMISSION AND CONSENT FORM

In consideration of services rendered, I agree to pay all charges incurred for my account as the patient and/or as the responsible party. In the event that I default in the obligation of payment to my provider, I understand that my account(s) can be placed with a collection agency or attorney for collection. I further agree to pay reasonable attorney fees, collections, fees, and court costs if my account(s) is placed for legal or third-party collection action.

I understand that I am financially responsible to my provider for all charges not covered, approved, or considered necessary by my insurance. I will pay at the time of service or have agreeable payment arrangements set up with my provider.

I also give consent to be contacted by my provider and their Designated Business Associates through any medium, including but not limited to wireless cell phone, email, and landline telephone. By providing your cellular number you are agreeing to be contacted by the provider and any entity working on the provider's behalf at that cellular number, and if necessary, by an automated dialing or messaging systems.

Provider Name: Susan Anderson

Family Health Care of Gallatin, PLLC

Patient: _____

Guarantor: _____

Date: ___-____-_____