PATIENT REGISTRATION FORM

*****Today's Date:*** ______________________ ***Clinic Name:*** ______________________

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** ______________ ***First Name:** ______________ **Middle Initial:** ______

***Address:** ______________________________

City: ______________ **State:** ______________ **Zip:** ______________

Home Phone #: (______) ______-______ ***Social Security #:** ______________

***Date of Birth:** ______________ **Age:** ______ ***Sex:** ______ **Marital Status:** ______ **Drivers Lic#:** ______

***Employer Name and Address:** ______________________________

______________________________ **Work Phone #: (______) ______-______**

E-mail Address: ______________________ **Cell Phone #: (______) ______-______**

Emergency Contact Name: ______________________ **Emerg Phone #: (______) ______-______**

Please tell us how you heard about us: ______________________ ***Referred by*** ______________

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient:** **Self** ______ **Spouse** ______ **Parent** ______ **Other** ______________

***Last Name:** ______________ ***First Name:** ______________ **Middle Initial:** ______

***Address:** ______________________________

City: ______________ **State:** ______________ **Zip:** ______________

Home Phone #: (______) ______-______ ***Social Security #:** ______________

***Date of Birth:** ______________ **Age:** ______________ ***Sex:** **Female** ______ **Male** ______

***Employer Name and Address:** ______________________________

______________________________ **Work Phone #: (______) ______-______**

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : ______________________ ***Insured's Name:** ______________________

Insured's Social Security #: ______________ ***Insured's Date of Birth:** ______________

***Policy / ID #:** ______________ ***Group #:** ______________ **Eff Date:** ______________

Claims Address & Phone: ______________________________

SECONDARY INSURANCE:

Plan Name : ______________________ ***Insured's Name:** ______________________

***Insured's Social Security #:** ______________ ***Insured's Date of Birth:** ______________

***Policy / ID #:** ______________ ***Group #:** ______________ *** Eff Date:** ______________

Claims Address & Phone: ______________________________

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.** ***ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ______________________________ **Date of Birth:** ______________
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

GUARANTOR SIGNATURE: ______________________________ **DATE:** ______________
(If different from patient)

GUARANTOR NAME (Please Print): ______________________________

HIPAA Notice of Privacy Practices

Female Health Associates of North Texas

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;
- The right to receive confidential communications concerning your