Portland Medical

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: [Last Name] First:	Middle: [Initial]	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no:	Cell phone no.:
Email address	Occupation:	Employer/Address

Language: Ethnicity:

Please list what pharmacy you would like to use: ○

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different): Email:	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

Today's Date: _____

First Name:_____Last Name:_____DOB_____

PAST AND PRESENT MEDICAL CONDITIONS: CIRCLE ALL THAT APPLIES TO YOU

Alcohol/Drug Problems
Acid Reflux
Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bipolar Disorder
Blood clots
Cancer-type_____
Colon problem
Congestive Heart Failure
COPD
Dementia
Depression
Diabetes
Emphysema
Gout
Fibromyalgia
Heart Attack
Heart Disease
Hepatitis- type___
High Blood pressure
High Cholesterol
HIV/AIDS
Kidney Disease
Liver Disease
Migraine Headaches
Prostate Problem
Seizure Disorder
STD-type_____
Sleep Apnea
Stroke
Thyroid Disorder
Other_____
_____

MEDICATIONS: MEDICATIONS YOU CURRENTLY TAKE INCLUDING OVER THE COUNTER MEDICATION

MEDICATION	DOSE/DIRECTIONS	MEDICATION	DOSE/DIRECTIONS

ALLERGIES:_____

SURGICAL HISTORY: LIST YOUR PREVIOUS SURGERIES

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY: CHECK ALL THAT APPLY

	LIVING	CANCER (TYPE)	DIABETES	HIGH BP	HIGH CHOLESTEROL	THYROID PROBLEM	LIVER DISEASE	DEMENTIA	DEPRESSION
FATHER									
MOTHER									
SIBLINGS									
CHILDREN									

SOCIAL HISTORY: CIRCLE ALL THAT APPLY

Marital Status: Never married / Married / Divorced / Separated / Widowed / Partnered – Significant Other
Tobacco Use: Never / Previous smoker (QUIT DATE _____)(YRS SMOKED____)(PACKS PER DAY____) Current Smoker (PACKS PER DAY____) (YEAR STARTED ____) / Smokeless Tobacco
Alcohol Use: None / Occasional / Regular- Number of cans/glasses
Exercise: Never / Occasional / Frequently / Times per week____ / Type

Portland Medical

HIPPA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my provider(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my provider. I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; If we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA)

Pt initials The patient understands that:

_____

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Portland Medical to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the office, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic 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 hereby authorize Portland Medical to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates may be found in Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable disease, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, an/or abortion-related information. I understand that I may, by placing my request in writing, to the Privacy manager, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text addresses at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by another form of electronic communication from the Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies.

Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned herby assigns to the medical practice all insurance benefits for services provided.

- The clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at ethe time of visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: 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 t the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient Representative

_____

Date

Relationship to Patient (if other than patient)_____

CLINIC STAFF USE ONLY

☐ Check if patient refuses to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (staff) signature Witness (staff) Printed Name

Date: _____

Patient's Full Name_____ DOB_____

I authorize the release of my medical records:

TO: **Portland Medical**
Address: 307 S Broadway
City, State, Zip Portland Tennessee 37148
Phone Number 615-323-9158 Fax: 615-323-9100
FROM:_____
Address:_____
City, State, Zip_____
Phone Number_____

For the purpose of:
____Permanent transfer to new provider
____Continuity of medical care
____Insurance of other third party reimbursement
____Other (Specify)_____

This release includes specifically (circle all that apply)

Office Notes	Laboratory Reports	Complete Medical Records
Radiology/Reports	History and Physical	EKG
Other_____		

1. I acknowledge and herby consent to such that the release of information may contain information regarding alcohol, drug abuse, psychiatric, HIV testing, AIDS, or other sensitive information ____(initials of pt).
2. I may refuse to sign the authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exam, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect or actions taken prior to receiving the revocation. Further details may be re-disclosed.
4. If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and ;may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it or a copy will be. Maintained in my permanent record.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient /Guardian/Patient Rep **Date:**

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. We request timely notification to our practice to enable another patient, waiting for an appointment, to be scheduled. Our goal is to provide the highest quality of care and service to you and other patients.

Please review our policy below:

Scheduled Procedures

48 hours notice is required to be timely

$100 fee for a "No-Show" or Cancellation without timely notice

Office Appointment

24 hours notice is required to be timely

$25 fee for a "No-Show" or Cancellation without timely notice

Definition of a "No Show": An appointment for which the patient does not attend and has not provided a call to cancel the office appointment or procedure appointment.

Patients who incur a "No Show" or untimely Cancellation three (3) or more times in a 12 month period, will dismissed.

Insurance does not cover this fee and payment is due at or before the next visit.
Patients are responsible for rescheduling the office appointment or procedure.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Please ensure to reschedule your appointment.

Questions about cancellation and no show fees should be directed to the Billing Department (615-323-9158). Please sign that you have read, understand and agree to this Cancellation and No Show Policy

Patient Name (Please Print)_____

Signature of Patient or Patient Representative _____

Date of birth_____