Patient Registration Form

Is today's visit work related?

If yes, do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? ☐ Yes ☐ No

How did you hear about us? ____________________

What's the reason for your visit today? ____________________

PATIENT INFORMATION

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip:

Home Ph#: Cell Ph#:

*Confidential Phone:

Home Email:

*Confidential Email:

Primary Care Physician (PCP):

PCP Address:

PCP Ph#:

Preferred Pharmacy:

Pharmacy Ph#:

Sexual Orientation:

Gender ID:

For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Home Ph#:

Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:

Race: ☐ I prefer not to answer

Ethnicity: ☐ I prefer not to answer

Best Form of Contact: ☐ Cell ☐ Home ☐ Email ☐ Mail

Best Time to Call: May we leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Relationship:

Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature ____________________ Date ____________________

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature ____________________ Date ____________________

NOTICE OF PRIVACY PRACTICES (SEE ATTACHED)

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature ____________________ Date ____________________

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 INOFORMATION. PLEASE REVEIW IT CAREFULLY.

Browne Medical LLC (dba 'AFC Urgent Care') is required by law to maintain the privacy of your Protected Health Information (PHI). This Notice describes how we will treat your PHI and how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. We may share your health information for treatment, payment and health operations as described in this Notice. This Notice also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by the physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may disclose PHI to family members, close friends or others concerned with your care and treatment.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred or are receiving treatment from to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used to obtain payment for your health care services. For example, we may provide PHI to your insurance company to obtain authorization and payment for services rendered. We may contact the Guarantor for your visit in order to obtain payment.

Healthcare Operations: We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign-in sheet at the registration desk where you will be asked to provide your name and insurance company. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

We may use or disclose your PHI in the following situations without your authorization: As required by Law, for Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Preliminary Research Identification, Research with an IRB waiver, Criminal Activity, Military Activity, to avert a serious and imminent threat to a person or the public, National Security, to comply with Worker's Compensation laws, Inmates, Disaster Relief and other Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

Other permitted and required uses and disclosures, such as for marketing or sale of your PHI to third parties, will be made only with your authorization. Once given, you may withdraw authorization at any time in writing delivered to the address given below.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in, a legal proceeding, and PHI that is otherwise prohibited.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. Your request must be in writing, delivered to the address given below, and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request and if we believe it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another health care professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location by notifying us in writing, delivered to the address given below.

You have the right to obtain a paper copy of this notice from us, upon request to the Clinic Manager or our Privacy Officer.

You may have the right to ask us to amend your protected health information. If we deny your written request for amendment, you have the right to deliver a statement of disagreement with us at the address given below and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Your request must be in writing, delivered to the address given below. We are required to notify you if your unsecured PHI is involved in a reportable breach.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. Or, you may file a complaint with us by mail or by contacting Margaret Franco, Practice Administrator, i.e. our Privacy Officer at the following address or phone number: 908.222.3500
We will not retaliate against you for filing a complaint.

We reserve the right to change the terms of this notice. Any change will apply to all PHI that we maintain. We post our current policy at each location and on our website. All written requests must be delivered to the Clinic Manager or mailed to HIPAA Privacy Officer.

I have reviewed the Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

Signature ______________________ Date ______________