### Medical Center Podiatry, P.C.

# REGISTRATION FORM

|  |
| --- |
| (Please Print) |
| **Today’s Date**:  |       |
| PATIENT INFORMATION |
| Patient’s Last name:       | First:       | Middle:       | [ ]  Mr.[ ]  Mrs.[ ]  Dr. | [ ]  Miss[ ]  Ms. | Marital status:  |
|  |  |  | Single [ ]  Mar [ ]  Div [ ]  Sep [ ]  Wid [ ]  |
| **Birth Date**: | **Age**: | **Sex:** [ ]  F[ ]  M | **Language:** | **Race:** | Shoe Size: |
|  |  |       |       |       |       |  |  |
| Street Address: | Social Sec #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|       |       | Cell Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| P.O. Box: | City: | State: | ZIP Code: |
|       |       |       |       |
| Occupation: | Employer: | Employer phone no.: |
|       |       | (     )       |
| Chose referred to clinic by (Please check one box): [ ]  Dr.  | [ ]  Family | [ ]  Friend | [ ]  Insurance plan | [ ]  Hospital |
| [ ]  Yellow Pages | [ ]  Close to home/work | NAME of Person/Dr. referred:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |       |
| Other family members seen here: |       |
| Pharmacy Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email** Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for your medical information to be sent to you. |
| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist.)**WE DO NOT TAKE MEDICAID or TRICARE STANDARD- Must pay for services at time of visit.** |
| Subscriber’s name: | **Birth Date:** | Patient’s relationship to subscriber: |  |
|       |       |      [ ]  Self [ ]  Spouse [ ]  Child [ ]  Other |  |
|  |  |  |  |  |
| In case of Emergency |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home/cell phone no.: | Work phone no.: |
|       |       | (     )       | (     )       |
| I authorize payment of insurance benefits directly to Medical Center Podiatry, P.C. I understand that I am to pay all charges not covered by my medical insurance, including deductibles, copays, and non-covered services at time of the visit.  **WE DO NOT TAKE MEDICAID or TRICARE STANDARD and must pay for services at time of visit.**   **WE DO NOT BILL FOR CO-PAYS.** |
|  |  |  |  |  |
|  | Patient/Guardian signature |  | Date |  |

**Medical Center Podiatry, P.C.**

**Consent for Treatment and Release of Information**

I AUTHORIZE Medical Center Podiatry, P.C. to perform medical treatment.

I CONSENT to Medical Center Podiatry, P.C. use and disclose of all individually identifiable personal, health financial, and demographic information (know as Protected Health Information or PHI) for the purposes of:

* Providing medical treatment
* Obtaining payment and reimbursement
* Obtaining authorizations from my insurance for test (were required)
* Requesting healthcare services from other providers
* Cooperating with other providers for medical treatment
* Fulfilling requests for information when specifically authorized by me
* In addition, doing all other things directly related to providing healthcare to (reminders, messages)

The above purposes and all other uses are know collectively as Treatment, Payment and Other Healthcare Operations or TPO and this information may include or be related to Psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy. You may review or receive a copy of our entire Notice of Privacy Practices upon request.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Medical Center Podiatry, P.C. when needed for purposes of TPO.

I CONSENT to Medical Center Podiatry, P.C. discussing any or all of my medical care including evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person contact(s).

 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been given the opportunity to review and agree with the terms and conditions of Medical Center Podiatry, P.C.’s Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

**I understand that should I choose not to consent to the terms and conditions of Medical Center Podiatry, P.C.’s Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.**

PATIENT’S NAME (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signs consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.

PHONE MESSAGE CONSENT

Your physician or staff members may need to contact you. Please fill out the information below.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In an effort to protect your privacy, we have developed a policy regarding leaving medical information.

We will not leave message with anyone except the patient/guardian, on an answering machine or voice mail unless we have your WRITTEN permission to do so.

I give Medical Center Podiatry, PC permission to leave messages regarding my medical care at the following numbers. Please initial all that apply.

My cell voice mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

My home answering \_\_\_\_\_\_\_\_\_\_\_\_\_ (initials)

My office/work voice mail \_\_\_\_\_\_\_\_ (initials)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

You agree, in order for us to service your account or to collect monies you may owe,

Medical Center Podiatry, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

1/We have read this disclosure and agree that Medical Center Podiatry,P.C., its employees

and/or agents may contact me/us as described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature Date