Registration Form

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Account #		SSN		Home #	
Last Name		Suffix		Work #	
First Name		Preferred Name		Cell#	
Middle		Marital Status		Gender	
Address		Employment ☐ FT ☐ PT		Date of Birth	
Address		Student ☐ FT ☐ PT		Primary Care Doctor	
City		State		Zip Code	
Email		Employer			

HIPAA Contact Information – *these contacts are authorized to give/receive medical and financial information*

Name	Relationship	Contact Info (Phone #)

Guarantor Information (Responsible for Bill)

Gender ______ Date of Birth ______ SSN ______

Guarantor Name ______ First ______ Middle ______ Last ______

Home Phone ______ Work Phone ______ Cell Phone ______

Mailing Address ______ City, State Zip ______

Emergency Contacts

Name	Relationship	Contact Info (Phone #)

Meaningful Use Information

Race ______ Ethnicity ______ Language ______

Rural Health: *Please circle all that apply:*

Homeless: T / F Veteran: T / F
Migrant: T / F Seasonal: T / F

If you do not have insurance, please answer the questions below:	Yes	No
1. Is the patient under the age of 21?	☐	☐
2. Is there anyone living in the patient's home under the age of 19?	☐	☐
3. Is the patient pregnant?	☐	☐
4. Is the patient currently receiving Social Security Disability benefits?	☐	☐
5. Does the patient currently have a disability or Medicaid Application pending?	☐	☐
6. Does the patient identify as having a disability?	☐	☐

If you provide your insurance card(s), you do not have to complete this section:

Insurance Information - PRIMARY

Subscriber's Relationship to Patient ______

Subscriber Name ______ DOB: ______

Certificate # ______

Insurance Carrier ______ Claims Mailing Address ______

Group Name ______ City, State, Zip ______

Group # ______ Phone Number ______

Insurance Information - SECONDARY

Subscriber's Relationship to Patient ______

Subscriber Name ______ DOB: ______

Certificate # ______

Insurance Carrier ______ Claims Address ______

Group Name ______ City, State, Zip ______

Group # ______ Phone Number ______

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Acknowledgement of Receipt of Notice of Privacy Practice (HIPAA)

Patient Name: ______________________________ **Patient Number:** ________________
MSJMRN: __________________ **(Enterprise Number)** **Patient DOB:** ________________
Patient Phone: __________________

☐ I have been presented with a copy of this "Notice of Privacy Practices."

☐ Yes ☐ No I have been offered/received information about my rights and responsibilities as a patient or the legal representative for the patient.

Preferred contact method:

☐ Phone ____________________ ☐ Written ☐ Email __________________________

PATIENT QUESTIONNAIRE **Add as HIPAA Note in Allscripts**

Please list the family members or other persons, and their relationship to you whom we may inform about your general medical condition and your diagnosis (i.e., treatment, payment, and healthcare).

Authorized Person	Relationship	Phone Number(s)	Cell Phone	Alternate Phone

CONTACTS ONLY IN CASE OF EMERGENCY **Add to the Account Tab in Allscripts**

Please list a family members or other person, and their relationship to you whom we may inform about your general medical condition and your diagnosis (*i.e., treatment, payment , and healthcare*).

Authorized Person	Relationship	Phone Number(s)	Cell Phone	Date of Birth (if known)

PATIENT CONTACT INFORMATION

ADDRESS: Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home***.

Mailing Address: ____
Street **City** **State** **Zip**

PHONE: What phone number should we call about your appointments, lab, radiology results, or other health care information ***If other than your <u>home</u> phone number:*** # ______________

☐ Yes ☐ No Can confidential messages be left on your answering machine or voicemail?

***** I am fully aware that a cell phone is not a secure and private line. *****

Signature: ______________________________ **Date:** ____________________

Check appropriate box below:

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Executor of Estate ☐ Attorney in Fact ☐ Other ____________

Witness: ______________________________ **Date:** ____________________

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Consent and Authorization Form

CONSENT FOR TREATMENT

I authorize Mission Health, including: Mission Hospital, Mission Medical Associates (MMA), Blue Ridge Medical Center (BRMC), McDowell Physician Practices (MPP), and Angel Physician Practices personnel to perform on me the care necessary to diagnose and treat any condition as directed by my medical provider. I understand I have the right to be informed by my medical provider(s) of the nature, purpose and any risks of any proposed operation or procedure and any available alternative methods of treatment.

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I authorize Mission Health to furnish necessary medical information relating to this treatment to any insurance company, governmental or charitable agency and their agents, and any professional review organization with whom I may have insurance coverage or who may be assisting in payment of my medical expenses. I also authorize Mission Health to release any medical information to my referring physician, primary care physician, treating physician, consulting physicians, and hospital based physicians, as well as, to any licensed provider, health care agency, or medical or nursing facility to which I am referred or transferred for further medical care. **This authorization shall remain in effect unless revoked by me.**

ASSIGNMENTS OF INSURANCE BENEFITS

I authorize payment of any insurance benefits to be made directly to Mission Health, Mission Hospital, MMA, BRMC or MPP. I authorize and direct all insurance entities to furnish Mission Health with all information regarding my benefits, status of claim, reasons for non-payment and other information deemed necessary by Mission Health.

FINANCIAL AGREEMENT

For all services and/or supplies not covered or deemed not medically necessary by my health plan, I agree to accept financial responsibility and to pay Mission Health directly. I understand that full payment is due within thirty (30) days of billing or as otherwise arranged by mutual consent of both parties.

PRIVACY

I have been provided with the opportunity to review the *Notice of Privacy Practices* document which describes how Mission Health will use and disclose my information and informs me of my rights relating to my information. Mission Health also participates in an electronic health information exchange which allows the sharing of information for appropriate purposes. I agree that my information will be included in this electronic network unless I choose to opt-out.

PATIENT RESPONSIBILITIES

Among other responsibilities, I understand that I am expected to keep and be on time for my medical appointments, and that repeated late arrivals or no-shows on my part may ultimately result in discharge from the practice.

I CERTIFY THAT I HAVE READ THE ABOVE, THAT THE ABOVE HAS BEEN EXPLAINED TO ME AND THAT I MAY BE PROVIDED A COPY OF THE ABOVE UPON REQUEST. I VOLUNTARILY SIGN THIS FORM AND UNDERSTAND I MAY REVOKE THIS CONSENT AND AUTHORIZATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN BASED ON IT. I FURTHER CERTIFY THAT I AM THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE AND I AM AUTHORIZED TO EXECUTE THIS FORM AND ACCEPT ITS TERMS.

Patient (Please Print) ______________ **DOB** ______________ **Date** ______________

Signature: ______________ Check appropriate box below:

☐ Parent ☐ Legal Guardian ☐ Authorized Legal Representative ☐ Other Individual Authorized to Consent to Healthcare for a Minor (Authorization Form Required)

Witness ______________ **Date** ______________

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