PRIME MEDIC PA
PRIMARY CARE

FOR STAFF USE ONLY
PROVIDER SEEN:
CC POLICY:
ENTERED BY:

PATIENT REGISTRATION FORM

Last: _____ **First:** _____ **MI:** _____

Gender: ☐Male ☐Female **Date of Birth:** _____ **Social Security:** _____

Mailing Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Mobile Phone: _____ **Email:** _____

Preferred Language: _____ **Marital Status:** _____ **Race/Ethnicity:** _____

Emergency Contact #1: _____ **Phone #:** _____

Relationship: ☐ **Parent** ☐ **Spouse** ☐ **Child** ☐ **Sibling** ☐ **Other:** _____

Emergency Contact #2: _____ **Phone #:** _____

Relationship: ☐ **Parent** ☐ **Spouse** ☐ **Child** ☐ **Sibling** ☐ **Other:** _____

Employer's Name: _____ **Occupation:** _____

Employer's Mailing Address: _____ **Suite #:** _____

City: _____ **State:** _____ **Zip:** _____

Preferred Pharmacy: _____ **City:** _____

Do you have an advance directive?

☐ YES ☐ NO

If yes, please make sure our office has a copy of your advance directive on file.

INSURANCE

Primary Insurance: _____ **Policy #** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____

Secondary Insurance: _____ **Policy #** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign, transfer and set over to Prime Medic PA, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I also acknowledge and agree to adhere to the Office/Financial Policies. In addition, I authorize Prime Medic PA to obtain prior prescription history, when medically necessary.

Signature of Patient or Personal Representative _____ **Date** _____

Financial Acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

Signature of Patient or Personal Representative _____ **Date** _____

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PATIENT HISTORY
Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

Date	Hospital/Facility	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries

Date	Hospital/Facility	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Father: ☐ Alive ☐ Deceased
Mother: ☐ Alive ☐ Deceased

(fill in blank with number)

Brothers: Alive: _____ Deceased:_____ Sisters: Alive: _____ Deceased: _____

Sons: Alive: _____ Deceased: _____ Daughters: Alive: _____ Deceased: _____

Social History

Do You Smoke?	☐ Yes	☐No	If yes, how often? _____
Have you smoked in the past?	☐ Yes	☐No	If yes, how often? _____
Are you subject to second hand smoking?	☐ Yes	☐No	If yes, how often? _____
Do you drink alcohol?	☐ Yes	☐No	If yes, how often? _____
Do you do recreational drugs?	☐ Yes	☐No	If yes, how often? _____
Do you drink caffeine?	☐ Yes	☐No	If yes, how often? _____
Do you exercise?	☐ Yes	☐No	If yes, how often? _____

Please list any other information that may be helpful.

_____
_____
_____
_____

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AUTHORIZATIONS, ACKNOWLEDGEMENT, AND CONSENT AGREEMENTS

Authorization for Treatment

I voluntarily authorize Prime Medic PA, its providers, and clinical staff to evaluate my health and provide routine medical care, including examinations, diagnostic testing, medications, treatments, and referrals considered appropriate for my condition. I understand that I may ask questions, refuse any recommended service, or withdraw my consent at any time. I acknowledge that no guarantee has been made regarding the outcome of my care.

Office and Financial Policies

I have read and understand the Financial/Office Policies of Prime Medic PA and agree to abide by its guidelines.

Consent to Receive Text Messages

I consent to receive SMS or Texts Messages for the purpose of collecting payments, appointment reminders, and notification of messages on my portal.

Consent to Obtain Prescription History

I provide informed consent to Prime Medic PA to obtain and review my prescription history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care.

HIPAA

I acknowledge that I received Prime Medic, P.A.'s Notice of Privacy Practices, which explains how my health information may be used or disclosed and describes my privacy rights. I understand that I may request a current copy at any time.

Approved HIPAA Contacts & Disclosure of Protected Health Information

Keeping information private is important to us and, by default; we will only disclose information related to the patient's BILLING ACCOUNT and MEDICAL CONDITIONS to the parent or legal guardian. Please note, in order to share protected health information to your spouse, they must be listed as an approved contact. The following names are people I would like to be involved in, or have access to my protected health information. I give permission for Prime Medic PA to share my protected health information with:

Contact #1: _____ **Phone #:** _____ **Relationship:** _____

Contact #2: _____ **Phone #:** _____ **Relationship:** _____

Contact #3: _____ **Phone #:** _____ **Relationship:** _____

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Office & Financial Policy, Consent to Obtain Prescription History, and Approved HIPAA Contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

_____ _____

Patient Name DOB

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

PRIME MEDIC PA
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ADVANCED PRIMARY CARE MANAGEMENT / CHRONIC CARE MANAGEMENT CONSENT

About These Services

Advanced Primary Care Management and Chronic Care Management provide ongoing support between office visits. Depending on the program and the patient's needs, services may include:

- Developing and updating a personalized care plan
- Reviewing medications, test results, and health concerns
- Coordinating care with specialists, hospitals, pharmacies, and other providers
- Following up after emergency room visits or hospital stays
- Helping manage chronic conditions and preventive-care needs
- Communicating with the patient or caregiver by telephone, portal, or other approved methods
-

Services may be provided by Prime Medic, P.A.'s providers, clinical staff, or authorized care-management personnel under the direction of the billing provider.

Patient Consent and Acknowledgment

By signing below, I acknowledge and agree that:

1. I voluntarily consent to participate in the programs named above depending on my clinical needs and care plan.
2. Prime Medic, P.A. may contact me and coordinate my care with healthcare providers, pharmacies, facilities, caregivers, and others involved in my care as permitted by law.
3. Only one practitioner or provider may furnish and bill for the selected care-management service during a calendar month.
4. These services may be billed monthly to my insurance. Deductibles, coinsurance, copayments, or other cost-sharing may apply, and I am responsible for amounts not covered by my insurance.
5. I may stop these services at any time by notifying Prime Medic, P.A. Cancellation will become effective at the end of the calendar month.
6. My care plan will be maintained as part of my medical record, and a copy will be made available to me or my caregiver.
7. These services do not replace routine appointments or emergency medical care. I should call 911 or seek emergency care for urgent or life-threatening symptoms.
8. My consent will remain in effect until I withdraw it or begin receiving the service from another billing practitioner.

I have had the opportunity to ask questions and understand that participation is voluntary. This designation is effective as of the date below and remains in effect until revoked by me.

Program Selected

☐ **Advanced Primary Care Management (APCM)**
☐ **Chronic Care Management (CCM)**
☐ **Both / either, dependent on my clinical needs and care plan.**

Patient/Representative Signature: _____

Printed Name: _____ **Date:** _____

Relationship to Patient, if applicable: _____

Verbal Consent Documentation

☐ Verbal consent was obtained and documented in the patient's medical record.

Staff Name/Signature: _____ **Date:** _____

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CREDIT CARD "SIGNATURE ON FILE" AUTHORIZATION FORM

At **Prime Medic PA**, we ask that you keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account. *As a courtesy, we will call and speak to you prior to processing any transaction.*

I authorize Prime Medic PA, to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐**Amex**☐**Visa**☐**MasterCard**☐**Discover Card Number** _____

Expiration Date _____**Security Code**_____ **Cardholder Name** _____

Billing Address _____

City _____ **State** _____ **Zip** _____

E-Mail_____
(for receipts of payment please fill in your email. Your receipt will be published to the patient portal)

Signature _____

I (we), the undersigned, authorize and request **Prime Medic PA** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by **Prime Medic PA.**

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to **Prime Medic PA in** writing and the account must be in good standing.

☐ **Patient declines keeping a card on file and will provide a card or card number or alternate form of payment to Prime Medic PA when liable for charges for services provided.**

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

PRIME MEDIC PA
PRIMARY CARE

S. Cherlo, MD | Anand Basi, MD | Mary Casebolt, APRN | Andrew Gold, RPAC | Susan Vasquez, NP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

_____

Phone _____ **Fax** _____

To furnish full details of medical care and treatment for:

Patient Name _____**D.O.B.** _____

Address_____

City/State/Zip _____ **SS#**_____

Please release all of the following requested medical records (selected below) to our providers at the fax number listed below:

☐ History
☐ Cardiac Reports
☐ H&P
☐ All
☐ Labs
☐ Plan of Care
☐ Testing (xray,mri,etc)
☐ Other: _____

Reason for records: _____

- I understand that this information may include results relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of acquired immune Deficiency Syndrome (AIDS) or related conditions, treatment for drug/alcohol abuse, mental/behavioral health or psychiatric care, excluding psychotherapy notes.
- I understand that our providers may change a fee for costs associated with processing this request
- Our providers may deny this request to inspect & copy certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional will review your request & the denial. The person conducting the review will not be the person who denies the request. The providers will then comply with the outcome of the review.
- This authorization is given freely with the understanding that:
    1. I may revoke this authorization at any time, except where information has already been released.
    2. The revocations must be in writing and a form is available from the medical record department.
    3. This authorization will expire 180 days from date of signature unless otherwise specified.
    4. Our providers may not condition treatment or payment upon obtaining this authorization.
    5. A photocopy or fax of this authorization is as valid as the original.
    6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient/Guardian Signature _____ **Date** _____

Staff Signature _____ **Date** _____

PLEASE FAX REQUESTED RECORDS TO 281-592-8699