PATIENT REGISTRATION – OVER 18 YEARS OF AGE

Today's Date: _____
(Please print and complete all blanks)

Patient Name: _____
(First) (Middle) (Last)

Address: _____

City, State, Zip: _____

Preferred Phone Number: _____

Sex: **Race:** **Date of Birth:** **Marital Status:** _____

Email Address: _____

Employment Status: **Full-time** **Part-time** **Disabled** **Retired** **Unemployed** **Student**

Occupation: _____

Employer's Name: _____

Employer's Address: _____

IF FULL-TIME STUDENT:

School's Name: _____

School's Address: _____

REFERRING PHYSICIAN OR ORGANIZATION
Full Name_____
Office Address_____
City/State/Zip_____
Office Telephone No,._____
Specialty_____

PRIMARY CARE PHYSICIAN
Full Name_____
Office Address_____
City/State/Zip_____
Office Telephone No._____

PHARMACY INFORMATION
Name_____
Address_____
City/State/Zip_____
Telephone No,._____

IN CASE OF EMERGENCY CONTACT:
Name_____ **Relationship**_____
Phone_____

Adelita M. Segovia, MD
Daniel B. Reising, MD
Michael Shanker, MD
Carolyn Auffenberg, MD

Patient Name:_____
First Middle Last

MEDICAL CONSENT FOR TREATMENT:

I request and authorize Dr. Adelita Segovia, Dr. Daniel B. Reising, Dr. Michael Shanker, Dr. Carolyn Auffenberg and their associates/assistants/employees, to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered advisable by my provider for my health and well-being and herein authorize them to administer any medical treatment as deemed necessary. I acknowledge that no representations, warranties, or guarantees as to result or cures have been made to me or are relied upon by me.

Signature:_____

GUARANTEE OF ACCOUNT:

Dr. Segovia, Dr. Reising, Dr. Shanker and Dr. Auffenberg are not in network providers for insurance plans and as such, payment in full is required at the time of service. Payments can be made by cash, check, Visa, Master Card, Discover, and American Express or FSA/HSA cards. Please complete the attached authorization form so that our office is able to confidentially retain your credit card information to cover fees for visits. Additionally, please note that checks returned to our office by the bank will incur a $35.00 fee.

If you would like to submit a claim to your insurance company for out of network benefits, we will provide you with a Superbill which contains all required information. A claims address is usually located on the back of your insurance card. Any reimbursement from your insurance company will then be made directly to you. Should you have questions, we are happy to assist you with this process.

A scheduled appointment is a commitment to the work between you and your provider and a contract between you both. Since the scheduling of an appointment involves the reservation of time specifically for you, please give notification within 24 hours if your are not able to keep your appointment. Emergencies do occur and we will make every effort to accommodate your schedule. However, you will be charged for your appointment at the doctor's regular rate after one missed session or failure to cancel your scheduled appointment within 24 hours. Appointment reminders are sent as a courtesy, it is your responsibility to maintain knowledge of appointment days and times to avoid a missed appointment charge.

Additional charges also include fees for letter writing, paperwork or documentation completion. Should you incur a balance on your account, our office will send you a statement summarizing the charges due. Upon receipt of the statement, please remit payment to us directly as soon as possible. It is within the rights of our office to take the appropriate actions needed to collect this balance. By initialing below, you are acknowledging your understanding that if your account is submitted to an attorney or a collection agency, if litigation in court is required, or if your past due status is reported to a credit agency, the fact that you have received treatment at our office may become a matter of public record.

I understand that I am responsible to pay this financial obligation in full. If, for some reason I am unable to pay this obligation in full when the balance is due, I will be held accountable for any and all late fees, collection fees, interest or finance charges, etc. that may accrue.

_____ (Initials of Person Authorized to Consent)

NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Initials of Person Authorized to Consent)

APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

Appointment reminders can be sent to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointment. Please indicate your preference.

I consent to receiving appointment reminders and other healthcare communications/information from the practice of my provider.

_____ I would like to receive appointment reminders via text message at the following number: _____.

_____ I would like to receive appointment reminders via an email message at the following address: _____.

_____ I would like to receive appointment reminders via an automated telephone message to the following home phone number: _____.

_____ None of the above – I'll remember by appointments on my own (Please note that missed appointment fees STILL apply).

I give permission for telephone messages regarding protected health information to be left at the following numbers (check all that apply and the applicable number on the line provided)

____ Home Phone (including voicemail/answering machine): _____

____ Cell Phone (including voicemail): _____

____ Other Phone (please specify):_____

_____ (Initials of Person Authorized to Consent)

Unless we have made another agreement, our office uses email communication and text messaging only with your permission and for administrative purposes including setting and changing appointments, billing matters, and other related issues. Please be aware that providers cannot guarantee the confidentiality of any information communicated by email or text. Please know that email and texts are not checked with regularity, and responses may not be immediate, so these methods **should not** be used in the case of an emergency or to discuss clinical information.

_____ (Initials of Person Authorized to Consent)

PRESCRIPTION REFILLS/CONTROLLED SUBSTANCE POLICY

The fastest way to request a refill of your medication is to contact your pharmacy. Prescriptions for controlled substances MAY BE SUBMITTED ELECTRONICALLY to most pharmacies. In accordance with D.E.A., prescriptions for controlled substances MAY NOT be faxed or called in to a pharmacy- this is NOT an office policy, this is FEDERAL REGULATION.

When calling our office for a refill please speak slowly and clearly to provide us with the following information: Caller's name and phone number, Patient's name, date of birth, medication, strength, and quantity. Please give our staff a MINIMUM of TWO business days from the time of your request to have your prescription ready for pickup. If you would like your prescription mailed to your home or to an alternative address, please indicate that on the voicemail and verify the address.

I certify that I have read, understand, and agree to adhere to the aforementioned policies.

_____

PRINT Name of Responsible Party/Person Authorized to Consent

_____ _____

Signature of Responsible Party/Person Authorized to Consent Date

_____

Relationship to Patient