HOPE
INTEGRATIVE CARE

New Patient Registration Form Co-Pay:_____

General Information (please print)

Name: _____ DOB _____ Sex: __M __F

Primary address_____

City _____ State _____Zip _____

Home phone _____Work phone _____Cell phone _____

Emergency contact _____ Relationship _____Phone _____

E-mail _____ Authorize E-mail? ___Y ___N

Pharmacy name _____ Phone _____Fax _____

Employment status: ___employed ___not employed ___retired ___student

Employer: _____Occupation _____

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _____ NO _____ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of **HIC** permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Doctor Information

Referring Physician _____Specialty _____

Primary Care Physician _____Phone _____

Primary Insurance

Insurance name _____Subscriber's name _____

Insurance ID# _____

Social Sec # _____ DOB _____Relationship to insured _____

It is patient's responsibility to ensure PCP has provided the referral BEFORE your appointment.

Secondary Insurance

Insurance name _____Subscriber's name _____

Insurance ID# _____

Social Sec # _____ DOB _____Relationship to insured _____

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of **HIC** to enroll me in the ePrescribe Program.

Patient signature _____Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of **HIC** to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient signature _____Date _____

Insurance Providers

I authorize the physician and/or staff of HIC to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical care. I authorize and request my above named insurance company to pay directly to Hope Integrative Care for the amount due for medical Services. I understand that I am financially responsible for any services deemed non-Covered by my insurance Company.

Patient signature _____Date _____

Patient's Financial Responsibilities

I understand that I am financially responsible for services in the office, that my co-pay, deductible and previous balance must be paid before I see the doctor and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency after written notification is provided to the patient. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt.

Patient signature _____Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify **HIC** of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by **HIC** is the patient's responsibilities.

Patient signature _____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish***. I acknowledge that I have received a copy of the HIC'S Notice of Privacy Practices.***

_____ _____ _____

Printed name Signature Date signed