REGISTRATION AND ANNUAL UPDATE FORM

UPDATED 3/2023

PATIENT INFORMATION

Full Legal Name: Preferred name (if different): Preferred Pronouns (circle): They/their She/her He/his	Date of Birth: Gender (current gender identity): Sex assigned at birth:	Preferred method of contact for reminders (circle): *text* *phone msg* OK to leave messages on voicemail? ☐ Yes ☐ No	Phone Number(s): Home: Cell: ***Name(s) and phone number(s) of parents or legal guardian(s)*** ***(for patients under 18 y/o):***

Mailing address:		
Emergency-Only Contact:	Relationship to patient:	Emergency Phone #:
Pharmacy:	Social Security #:	

HIPAA CONSENT: This must be updated yearly. Without signed consent, we can NOT share information regarding your medical care (like lab results, appointments dates, etc) or billing to anyone, including family. Please list anyone you would like to have this information.

1. _____ **2.** _____

X_____

(Patient/Guardian SIGNATURE) **(Date)**

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner: _____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Indian/Native American ☐ Asian ☐Bi/Multi-racial: _____ ☐ Other: _____
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refused
Primary Language Spoken? ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Yes ☐ No
If English is your second language and you find it difficult to understand your provider, or you feel that your provider doesn't understand you, we highly encou medically trained interpreter rather than a family member. We will provide the interpreter for you when you are being seen in the office.

Occupation/Place of Employment: _____ Are you disabled? ☐ Yes ☐ No
Do you have any Advanced Directives for end-of-life decisions? ☐ Yes ☐ No If yes, what type? _____
Health Care Proxy (Power of Attorney) Name and Phone Number: _____

Do you receive assistance with tasks of daily living or with managing your health? ☐ Yes ☐ No

- If yes, who is helping? _____ Relationship to patient: _____

EMAIL Address: _____
*By giving this email address, I consent to being signed up for the Patient Portal.

INSURANCE INFORMATION

****Please fill out <u>ONLY</u> if patient is on spouse or parent's insurance plan****

If the patient has their own plan, this does not need to be filled out - as long as we have a copy of the card and the Patient Information section (above) is completed.)

Please give insurance card to the receptionist to be scanned. We are NOT responsible for filing claims if no card is on file

<u>PRIMARY INSURANCE</u> ☐Medicare ☐ NC Medicaid ☐ BCBS ☐Other			Policy #:
Name on the insurance card? :	SS # of the policy holder(required):	Birth date of Policy Holder(required):	Group #:

How is the **patient** related to the policy holder? : ☐ Self ☐ Child (covered under parent's insurance) ☐Spouse ☐ Other
How does your insurance have your **gender** listed? ☐ Male ☐ Female

<u>SECONDARY INSURANCE</u> Name: ☐None	Secondary Insurance policy holder: ☐Self ☐Same as primary insurance	Policy Holder DOB:	Policy #:

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Financial Policy, Office Policies, and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Community Family Practice, PA.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give any or new updated insurance information 3) Expenses not covered by insurance including labs 4) deductible not met 5) services rendered deemed medically unnecessary by insurance or non-covered/excluded services by your plan 6)not in network with your plan.

Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections reported to your credit.

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non-Sufficient Funds.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment, if necessary. Please allow 48 hours to respond to refill requests.

Missed Appointments: We charge $20.00 for any no-show appointment that is not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no-show" 3 appointments within 1 year, it is policy to dismiss you from the practice.

HIPAA:

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our office, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION MAY BE USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include: other physicians, laboratories, Accountable Care Organizations, and view/share information with Health Information Exchanges (HIE). To protect your privacy, we have business associate agreements with applicable organizations, requiring them to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

CUSTODY AGREEMENTS – If you have a child custody agreement/court order, we will ask for a copy to have on-file. Please reference our Custody Agreement Policy via the practice website communityfamilyonline.com for more information.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager at 828-254-2444.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES – I have received a copy of the Notice of Privacy Practices for Community Family Practice, PA.

Other Disclosures and Consents:

View and Share Aggregate Data –

I hereby grant consent to CFP to share or view aggregated data with Health Information Exchanges.

Authorization to mail, call, or text -

I certify that I understand the privacy risks of mail, phone calls, and text. I hereby authorize a CFP representative or my physician to mail, call, or text me with communications regarding my health care, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying CFP to that effect in writing.

Lab/X-Ray/Diagnostic Services –

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services, if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment -

I hereby consent to evaluation and treatment as directed by my CFP physician or his/her designee. I hereby consent to CFP obtaining and viewing my prescription history reported by outside sources.

Signature (All Policies, Disclosures, and Consents) including ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Refusal to sign does NOT prevent responsibility/obligation regarding this office's policies)

X_____Date_____