

Patient Registration Form

Patient Information

Patient Last Name		First Name		Middle Name	Maiden Name
Address (Street or PO Box)			City	State	Zip
Home Phone #		Work Phone #		Cell Phone #	
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____	Age	Social Security #	Driver's License #	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner			Spouse/Partner Name (if applicable)		
Employer Name		Employer Address			
Preferred Pharmacy Info Name: _____ Address: _____ Phone: _____			How did you hear about us?: <input type="checkbox"/> Family/Friend <input type="checkbox"/> Insurance <input type="checkbox"/> Internet/Website <input type="checkbox"/> Location / Drive By <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Community Event <input type="checkbox"/> Radio / TV		

Complete this Section only if the patient is a minor

Responsible Party

Responsible Party Last Name		First Name		Middle Name	Maiden Name
Address (Street or PO Box)			City	State	Zip
Home Phone #		Work Phone #		Cell Phone #	
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____	Age	Social Security #	Driver's License #	

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Claims Mailing Address (Street or PO Box)		Claims Mailing Address (Street or PO Box)	
City	State	Zip	
City	State	Zip	
Policy/Member ID Number	Group Number	Policy/Member ID Number	Group Number
Subscriber Name (Policy Holder)	Date of Birth	Subscriber Name (Policy Holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone#	Subscriber Employer	Work Phone#
Subscriber Employer Address (Street or PO Box)		Subscriber Employer Address (Street or PO Box)	
City	State	Zip	
City	State	Zip	

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat & Financial Responsibility

I hereby authorize employees and agents of Topcare Medical, PA / MD Medical Group (including physicians, physician assistants, and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that a physician assistant/nurse practitioner is not a doctor. I also understand that a physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the State board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. I understand that at any time I can refuse to see the physician assistant/nurse practitioner and request to see a physician.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this Section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Parent or Legal Guardian

Date

I hereby authorize and assign payment of medical benefits directly to Topcare Medical, PA (MD Medical Group - hereinafter "MDMG"). I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment and it is due upon request. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expense of MDMG, if any, including but not limited to, a collection fee of up to 25% of the debt should my account be assigned to a collection agency for collections. I have been instructed where to review MDMG's Patient Financial Policies and Rights and Responsibilities. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing below that I am responsible for payment of services in full before services are rendered.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat

Financial Responsibility

Acknowledgement of Receipt of MD Medical Group (MDMG) Notice of Privacy Practices

Privacy Practices Notification

The Health Insurance Portability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act are federal government regulations designed to ensure privacy and security of patient's protected health information (PHI) and to ensure that you are aware of your rights and how your medical information can be used in providing and arranging your medical care.

MDMG is furnishing you with its Notice of Privacy Practices, which are available in hard copy or at the company's website (www.clinicasmidocor.com ; www.mdkidspediatrics.com ; www.mdfamily.com), which provides information about how MDMG and its providers may use and/or disclose protected health information about you for treatment, payment, healthcare operations, and as otherwise allowed by law. By signing this form you acknowledge that you have received MDMG's Notice of Privacy Practices.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Communication Preferences

Communication of PHI

I hereby authorize **MDMG** to leave detailed, personal health information by the following means: (Please complete all that apply)

Voicemail message at my

home work cell number:

(area code and number)

Verbal message with my spouse or partner:

(name of spouse or partner)

(area code and number)

Verbal message with other family member:

(name of spouse or partner)

(area code and number)

Send automated text messages for appointment reminders/schedule changes/notifications of normal labs or other diagnostics

I acknowledge and understand that this Authorization will be kept in my medical record and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify **MDMG** in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Race, Ethnicity, and Language

We would like you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Which category best describes your race?

- American Indian or Alaska Native

 Native Hawaiian or Other Pacific Islander
 Black or African American

 Multiracial
 White

 Decline
 Asian (includes Pakistan or Indian origins)

Do you consider yourself Hispanic/Latino?

- Yes

 No

 Decline

What language do you feel most comfortable speaking with your healthcare provider?

- English

 Tagalog

 French
 Spanish

 Hindi

 Sign Language or other Auxiliary Aid or Service
 Vietnamese

 Italian

 Other _____
 Chinese

 Korean

 Decline

Emergency Communication and Patient Portal

Please choose the person that you would like to list as **Emergency Contact** in the event an emergency situation was to take place while in our office(s):

Name: _____

Contact Phone: _____

Patient Portal

- Yes I want to communicate my information with me through a secure system that is designed to keep my information safe. You will be notified via email when there is secure information for review.

Email: _____

****Requires a signed Patient Portal User Services Agreement**

- No I do not want to use electronic communication as a way to communicate my information to me.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date