



MEADOWS HEALTH

ADVANCED WOUND CARE

**NEW PATIENT REGISTRATION -
STANDARD FORM FOR ALL ENTITIES ASSOCIATED WITH SOUTHEAST REGIONAL PRIMARY
CARE CORPORATION AND/OR MEADOWS REGIONAL MEDICAL CENTER, INC. WITH WHICH
THIS CENTER IS ASSOCIATED**

Date: _____ **Primary Physician** _____ **Pharmacy:** _____

PATIENT INFORMATION

First Name Middle Last Name

Other Names Used Email Address Marital Status
(S, M, W, Sep, D)

May we contact you via email? Please circle Y or N. If no, what is your preferred method of communication?

Please circle Telephone or regular mail.

____/____/____ M or F _____
Date of Birth Sex Race Primary Language Ethnicity Social Security No.
(MM/DD/YY) (Check One) (XXX-XX-XXXX)

Patient Mailing Address (Street, Route, Apt. No.) City State Zip Code

Primary Phone Number Secondary Phone Number ***Please provide at least two (2) phone numbers**

Emergency Contact Name Phone Number Relation to Patient
(Must be different from primary phone number on file)

INSURANCE INFORMATION

Primary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

Policyholder's Name Date of Birth Employer Relation to Patient
(MM/DD/YY)

Secondary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

Policyholder's Name Date of Birth Employer Relation to Patient
(MM/DD/YY)

How did you hear about our office? Check One:

___ Referring Doctor ___ Newspaper ___ Billboard ___ Radio ___ Phone Book ___ Website

___ Friend - Who may we thank: _____

Other: _____

**NEW PATIENT REGISTRATION – ACKNOWLEDGEMENT AND DISCLOSURES
STANDARD FORM FOR ALL ENTITIES ASSOCIATED WITH SOUTHEAST REGIONAL PRIMARY
CARE CORPORATION AND/OR MEADOWS REGIONAL MEDICAL CENTER, INC. OF WHICH
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PHYSICIAN PRACTICES POLICY AND RELEASE OF INFORMATION

The following is a statement of our Financial Policy for services provided within our office and does not apply to any testing or diagnostic procedure performed outside of the physician practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.**

Initial: _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial: _____

When you receive a statement, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you must contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial: _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for our office to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator and/or other health benefit payor or representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization serves as permission to obtain a copy of your complete medical record for or from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, by communicating to the practice either in writing or verbally, followed by a written withdrawal.

Initial: _____

I understand that I am financially responsible for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits or claims to be paid directly to this office.

PATIENT NAME (PLEASE PRINT)

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

**ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTIFICATION FORM**

Signature below is acknowledgement that have been given and had the opportunity to read our **Notice of Privacy Practices**. Should you wish to read the Notice at any other time, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgment and authorization remains in effect until we are notified, in writing, by you of any changes.

Print Name _____ Date _____

Signature _____ DOB _____

Please list all additional authorized persons with whom we may discuss any of your medical information (**this includes scheduled appointments**):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

LAB PROCEDURES

This clinic may utilize an outside lab to process lab-related services that cannot be performed in our office. In that case you and/or your insurance company will receive a bill from the outside lab for your lab work.

To avoid out-of-network charges, **which will result in additional cost to you**, please let your doctor or the nurse know **immediately** if your health insurance policy requires us to send your lab work to another lab. Patients or guardians are responsible for communicating this insurance requirement to our staff at each appointment.

I have read and understand the above two Notices. I also understand that I will be responsible for all charges incurred related to out-of-network lab services.

Patient Name (please print) Date Patient/Guardian Signature

HISTORY FORM

NAME: _____

DATE OF BIRTH: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Blood/Lymphatic

- ___ Unexplained Lumps
___ Easy Bruising/Bleeding

Breast

- ___ Breast Lump(s)
___ Nipple Discharge

Cardiovascular

- ___ Chest Pain/Discomfort
___ Palpitations
___ Shortness of Breath

Neurological

- ___ Headaches
___ Memory Loss
___ Fainting
___ Clumsiness
___ Disorientation
___ Dizziness
___ Lack of Coordination
___ Involuntary Movement
___ Numbness
___ Paralysis
___ Tingling
___ Tremors
___ Weakness

Ears/Nose/Throat/Mouth

- ___ Difficulty Hearing/Ringing in Ears
___ Hay Fever/Allergies/Congestion
___ Trouble Swallowing

Endo

- ___ Cold/Heat Intolerance
___ Increase Thirst/Appetite

Eyes

- ___ Change in Vision
___ Eye Glasses
___ Contact Lens

Genitourinary

- ___ Painful/Bloody Urination
___ Leaking Urine
___ Nighttime Urination
___ Elevated PSA

Musculoskeletal

- ___ Muscle/Joint Pain
___ Recent Back Pain

Psychiatric

- ___ Anxiety/Stress
___ Sleep Problems

Constitutional

- ___ Recent Fever/Sweats
___ Unexplained Fatigue/Weakness
___ Unexplained Weight Loss/Gain

Respiratory

- ___ Cough/Wheezing
___ Snoring
___ Coughing up Blood
___ Daytime Drowsiness
___ Use Oxygen Equipment
___ Do not feel rested in the morning
___ Use Nebulizer
___ Use CPAP/BiPap
___ Supplier of Equipment
___ Pets - How many? Type:
___ Indoor/Outdoor:

Any Toxin Exposure?

- ___ Asbestos
___ Beryllium
___ Lead
___ Coal Dust
Other: _____

Gastrointestinal

- ___ Heartburn/Reflux
___ Blood or Change in Bowel Movement
___ Nausea/Vomiting/Diarrhea
___ Pain in Abdomen
___ Hemorrhoids
___ Loss of Bowel Control

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)

- ___ Heart disease: Specify type
___ Asthma/Lung disease
___ Polyps (type)
___ Cancer (specify)
___ Liver cirrhosis
___ Ulcerative colitis/IBS
___ High blood pressure
___ Diabetes
___ Bladder/Kidney disease
___ Kidney Stones
___ AIDS
___ Blood Clots in Leg
___ Pancreatitis
___ High Cholesterol
___ Thyroid problem
___ Bleed disorder
___ Anemia
___ Hemorrhoids
___ Peptic Ulcer

Other: _____

PERSONAL SURGICAL HISTORY: Indicate whether you have had any of the following surgeries (with dates and physician's name)

- ___ Coronary artery bypass graft (open heart surgery)
___ Cholecystectomy (gallbladder removed)
___ Appendectomy (appendix removed)
___ Hysterectomy (some/all of female reproductive organs removed)
___ Tonsillectomy/Adenoidectomy (tonsils/adenoids removed)
___ Colectomy (part of the bowel removed)
___ Joint Replacement
___ Stents in Vessels
___ Hernia Repair (list type)
___ Colonoscopy
___ EGD
___ Other

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

- ___ Cancer (specify type)
___ Heart disease
___ Genetic disorders
___ Diabetes
___ High Cholesterol
___ High blood pressure
___ Stroke
___ Bleeding or clotting disorder
___ Asthma/COPD
Other: _____

SOCIAL HISTORY:

Tobacco Use

- Cigarettes ___ Never ___ Quit Date
Current Smoker: packs/day ___ number of years
Other Tobacco: ___ Pipe ___ Cigar ___ Snuff ___ Chew

Alcohol Use

- Do you drink alcohol? Yes/No
Number of drinks/week

Caffeine Use

- Do you drink Coffee/Tea/Soft Drinks
Number of drinks/day

Signature _____

Date _____



GENERAL CONSENT FORM

SOUTHEAST REGIONAL PRIMARY CARE CORPORATION AND/OR ITS AFFILIATED ENTITIES OF WHICH THIS CLINIC IS ONE

Patient: _____ DOB: _____ Today's Date: _____

I, the undersigned, agree to the following:

(1) **CONSENT FOR MEDICAL TREATMENT**

I hereby voluntarily consent for care encompassing diagnostic, laboratory, imaging, examinations and surgical procedures and treatment by my physician/nurse practitioner, his/her assistants, designees or consultants, as may be necessary in the judgment of my physician/nurse practitioner. I also understand that I will be billed directly for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(2) **RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES**

Southeast Regional Primary Care Corporation (SRPCC) and this clinic (all-encompassing and hereinafter referred to as the "Clinic") are not responsible for valuables, including money, jewelry, glasses, dentures, documents and other personal items.

(3) **RELEASE FROM RESPONSIBILITY**

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(4) **AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT**

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic's charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic and utilization review nurse or case manager who may not be an employee of the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic and/or SRPCC system of entities operations.

(5) **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given a copy of the Clinic's **Notice of Privacy Practices**. My signature below acknowledges receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(6) **ASSIGNMENT OF BENEFITS**

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payors for the payment of all charges associated with my treatment. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to billing insurance, filing petitions, filing suit in name or on behalf of the Clinic or SRPCC or its assignees, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Party payor, the patient or guarantor.

(7) **FINANCIAL RESPONSIBILITY AGREEMENT**

I understand that I am financially responsible to the Clinic and its lawful assignees for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other Third Party Payor are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. Unless payment is made in full at the time of service, then patient authorizes the Clinic or its agents to obtain a credit report. Should the account be referred for collection to a collection agency, the undersigned agrees to pay all court costs of collection may include reasonable attorney fees of up to and including 15% of the debt involved. The undersigned patient and insured also agree that the Clinic or SRPCC or its assignees may apply any payments received from the patient against any other amounts due at the time from or for the undersigned patient. All amounts not paid when due may accrue interest at the rate of 1½% per month on the unpaid principal balance. If applicable, I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(8) **NON-CERTIFICATION OF SERVICES**

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies either all or part of their payment on the clinic account, I will pay the account in full upon demand.

(9) **CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING**

I authorize the clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(10) **MEDICAL EXCHANGE OF INFORMATION**

I hereby authorize the Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care.

(11) **ACKNOWLEDGMENT**

My signature below constitutes my acknowledgment and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent form will be valid and remain in effect as long as I am a patient of the Clinic.

I certify that I have read the foregoing, and I am either the patient or am duly authorized by the patient's general agent to execute the above and accept the terms.

Signature of Patient or Authorized Individual

Date

Relationship of Signer to Patient:

(self, mother, father, son, daughter or explain other)

Guarantor of Payment (If patient not signing)

If patient is unable to sign, state reason: _____

Witness

Date