

# Patient Registration Form PLEASE PRINT

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M. Initial: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex:  Female  Male Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: \_\_\_\_\_ email: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**PHARMACY NAME & PHONE NUMBER:** \_\_\_\_\_

## PARENT OR GUARDIAN INFORMATION (Only fill out if the patient is under the age of 18)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M. Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

## PRIMARY & SECONDARY INSURANCE INFORMATION (ALL insurance)

Insurance Plan Name: \_\_\_\_\_

**POLICY HOLDER NAME** (if other than patient): \_\_\_\_\_

DOB: \_\_\_\_\_ Sex:  Female  Male Relationship to Patient: \_\_\_\_\_

## HOW MAY WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

No  Yes: I may be contacted by e-mail at: \_\_\_\_\_

No  Yes: I may be contacted by phone at: \_\_\_\_\_

No  Yes: May we leave a message with your PHI at the number you have provided? **(MUST BE ANSWERED)**

Would you like to receive text messages regarding your appointment, lab results, etc.?

No  Yes: What number? \_\_\_\_\_

**DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# CRUMP MEDICAL

# Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **PRACTICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

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# CRUMP MEDICAL

# General Consent For Treatment

***As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).***

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. \_\_\_\_\_ (initial)

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of the above: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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**CRUMP MEDICAL**

# Patient Financial Policy

*This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

## **HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

## **It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

**We accept the following: Cash Check Credit Card (Visa, MasterCard, Discover, American Express)**

**A twenty-five dollar (\$25.00) returned check fee will be assessed to the patient account per incident.**

For convenience, payments may be made online at [www.ePayItOnline.com](http://www.ePayItOnline.com). To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who no-show may be subject to a no-show fee.**

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

\_\_\_\_\_ Initials

Patient and/or Debtor Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Additional financial explanations are continued on the next page*

# CRUMP MEDICAL

## BILLING INFORMATION

**STATEMENTS:** A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at [billing@phydata.com](mailto:billing@phydata.com) or call 615-851-6033. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <\$5.00> will not be refunded without specific request from the patient/debtor.

**DELINQUENT ACCOUNTS:** We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

**CONSENT TO CONTACT:** I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

**WAIVER OF CONFIDENTIALITY:** You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**MEDICAL RECORDS:** You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **\$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

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# CRUMP MEDICAL

# Authorization For Release Of Protected Health Information (PHI)

## SECTION A: This section must be completed for all Authorizations for Release or Right to Access

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Requestor's Name / Address / Phone No. (Who is receiving PHI): \_\_\_\_\_ Recipient's Name / Address / Phone No. (Who receives this form) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Address: \_\_\_\_\_

This authorization will expire on the following Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_

## SECTION B: DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes?  YES, then this is the only item you may request on this authorization.

**YOU MUST SUBMIT** another authorization for other items below.  NO, then you may check as many items below as you need.

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
<input type="checkbox"/> All PHI in Psychotherapy Medical Record		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Demographics	
<input type="checkbox"/> All PHI in Medical Record		<input type="checkbox"/> Imaging/Radiology		<input type="checkbox"/> Itemized Bill	
<input type="checkbox"/> History & Physical		<input type="checkbox"/> Pathology		<input type="checkbox"/> Claim Form	
<input type="checkbox"/> All Progress Notes		<input type="checkbox"/> Operative Notes		<input type="checkbox"/> Other:	
<input type="checkbox"/> Discharge Summary					

**I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV or AIDS results, testing or information.** \_\_\_\_\_ (Initial)

### I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. If I do not sign this form, my health care and the payment for my health care will not be affected
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it
6. I will receive a copy of this form after I sign it

## SECTION C: SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated

\_\_\_\_\_  
Signature of Patient/Guardian/Patient Representative

\_\_\_\_\_  
DATE:

\_\_\_\_\_  
Print Name of Patient's Guardian/Representative

\_\_\_\_\_  
Relationship to the Patient

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