**PATIENT REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** | | | | **Mi:** | | | **Last Name:** | | | | |
| **Date of Birth:** | **Age:** | | | **Sex: M / F** | | | | **SSN:** | | | |
| **Mailing Address:** | | | | | | | | **Apt. #:** | | | |
| **City:** | | | | **State:** | | | | **Zip Code:** | | | |
| **Language:** | **Race:** White  Black  Asian  Native American  Other  | | | | | | | | | | |
| **Ethnicity:** Non-Hispanic  Hispanic  | | | | | | **Email Address:** | | | | | |
| **Home #:** | | **Work #:** | | | | | | | | **Cell #:** | |
| **Marital Status:** S  M  D  W  **Spouse’s Name: DOB:** | | | | | | | | | | | |
| **Is patient residing in a Skilled Nursing Facility/Rehabilitation Center?:** Yes  No  | | | | | | | | | | | |
| If yes, **Name:** | | | | | **Telephone #:** | | | | | | |
| **Pharmacy:** | | | **City:** | | | | | | **State:** | | **Phone No.:** |

***Emergency Contact Information:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Home#:** | **Work #:** |  | **Cell #:** |

***Guarantor Information:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Address:** |  |  | **City:** |
| **State:** | **Zip Code:** | **Telephone #:** |  |

***Insurance Information:***

* Please have your insurance card(s) and driver’s license available for verification.
* Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of processing.

|  |  |
| --- | --- |
| **Primary Insurance:** | **Policy Number:** |
| **Secondary Insurance:** | **Policy Number:** |

I understand that North Georgia Primary Care may bill my health plan for the care I receive. It is the patient’s responsibility to understand their medical insurance and provide us with a current insurance card at the time of each service. If you have a HMO policy that requires a referral from your primary care physician, you are responsible to provide our office with a valid referral at the time of your visit. I agree that payments from my health plan may go directly to North Georgia Primary Care. All payments of any insurance deductibles, coinsurance, and co-payments are due when services are rendered, and I know that I may need to pay this before I am treated. **If I should receive the payments, I understand that I will be responsible for paying North Georgia Primary Care.** Medicare and other insurance companies will pay only for services that they determine to be “reasonable and necessary” under their contracts. If your insurance carrier determines that a service(s) is not reasonable and necessary, it will deny payment for that service(s). If your insurance carrier denies payment, the patient is to be personally and fully responsible for this payment. I understand and agree that if my plan does not pay the doctor, I will have to do so.

My signature on this form assures: (1) that North Georgia Primary Care may be paid directly by my health plan and, in some cases I may have to pay for my treatment; (2) that I am responsible for my belongings; (3) that I have received a copy of the North Georgia Primary Care Notice of Privacy Practices. I hereby authorize North Georgia Primary Care to furnish information to my insurance carrier(s) concerning my illness and treatment and assign to the physician all payments for medical services rendered to my dependents or myself.

**My Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For health care agent/guardian/surrogate/parent (circle one), I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the representative for this patient. Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent for Purposes of Treatment, Payment, and Healthcare Options

I consent to the use or disclosure of my protected health information by North Georgia Primary Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of North Georgia Primary Care. I understand that diagnosis or treatment of me by Bryan D. Hooker, M.D., and/or Nurse Practitioner. may be conditioned upon my consent as evidenced by my signature on this document. I consent to routine medical care rendered by the attending physician(s) at North Georgia Primary Care. I consent to treatment by a Physician’s Assistant or Advanced Practice Nurse acting under the supervision of Dr. Hooker. I attest that I am the legal guardian or parent of the patient.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. North Georgia Primary Care is not required to agree to the restrictions that I may request. However, if North Georgia Primary Care agrees to a restriction that I request, the restriction is binding on North Georgia Primary Care and Bryan D. Hooker, M.D., and/or Nurse Practitioner. I have the right to revoke this consent, in writing, at any time, except to the extent that Bryan D. Hooker, M.D., and/or Nurse Practitioners or North Georgia Primary Care has taken action in reliance on this consent. My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review North Georgia Primary Care’s Notice of Privacy Practices prior to signing this document. The North Georgia Primary Care’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the North Georgia Primary Care. North Georgia Primary Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

North Georgia Primary Care honors the patients and providers time, if you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment. Excessive no shows and cancellations are not tolerated. Please call the office to reschedule your appointment in a timely matter.

**We often need to contact patients by phone. If you are not available, do you give permission for the physician or the office staff to leave a message on your answering machine or voicemail?**

Please initial either ‘*Yes*’ or ‘*No*’ to indicate your response. If ‘*Yes*’, please provide the phone number where we can leave a message.

**Yes**: \_\_\_\_\_\_\_\_\_\_  **No**: \_\_\_\_\_\_\_\_\_\_

**Please list the name, relationship, and the phone number of each person with whom we are allowed to discuss your medical and financial information. Also, please indicate if we may leave a message on his/her answering machine or voicemail.**

**Name: Relationship: Phone Number: Message?:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient/Parent/Guardian Signature Date