PATIENT REGISTRATION FORM

Name: _____ S.S.N:_____

Birth Date: _____ Home Phone: _____Cell Phone: _____

Address: _____City:_____ State: _____

Zip Code: _____ Email: _____ Sex: M / F

CIRCLE: Married Single Widowed Minor Divorced Partnered for ___ years

Pharmacy Name, Address, and Telephone Number:

_____

Do you consent to automated text and voice messages such as appointment reminders and notifications? YES / NO Initials: _____

I authorize Primary Medicine, LLC to share my health information with the following individual(s). If at any time I wish to remove anyone, I will send a written request to the office:

_____

For detailed description of what information is to be shared, please request and complete a Health Information Sharing Form

Emergency Contact Full Name and Telephone Number

_____

Insurance Information

Person responsible for the account: _____ Relationship: _____

*** Must have Valid ID on file

1st Ins. Co: _____ ID: _____ Grp: _____

2nd Ins. Co: _____ ID: _____ Grp: _____

I certify that I, and/ or my dependent(s) have insurance coverage with _____ and assign directly to Primary Medicine, LLC, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Primary Medicine, LLC may use my healthcare information and may disclose such information to insurance payers for the benefits payable for medical services, or as required by state, federal, and local law.

Signature: _____ Date: _____

Relationship, if signed by someone other than patient: _____

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Primary Medicine appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a formality, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many Insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If you Ins. Carrier deny any part of your claim, or, if you or your physician elects to continue past your approval period, you will be responsible for your balance in full.

Co-Pay Policy

_____ Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

_____ I hereby authorize Primary Medicine through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize Primary Medicine, to release to appropriate agencies, any information acquired in the course of my or the above named patients' examination and treatment for the payment of services rendered.

Cancellation/ No show Policy

_____ We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call us 24-hours in advance to cancel your appointment or there will be an additional fee assessed of $25.00. I understand if I do not show for three appointments, I may be discharged from care. You will be notified in writing, via certified mail, if you are discharged from care.

Third Party Payments

_____ Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third-party liability you must obtain and provide us with all of the relevant information (claim number, phone number, contact person, and name and address of the insurance carrier) prior to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third-party liability information within 15 days of the date of service may result in any unpaid balances transferring to patient responsibility. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by the third party payer.

Statements

_____ A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Types of Payments

_____ Our practice accepts Visa, MasterCard, American Express, Cash, Check, and money orders are accepted. There will be a fee of $35 for any returned check.

Collection of Outstanding Balances

_____ All outstanding balances shall be due within 30 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care by Primary Medicine, LLC. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Treatment of Minors

_____ For all patients under the age of 18, the parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. We must have a valid Picture ID and contact information on file. A signed release will be required to treat unaccompanied minors ages 16-18.

I have read the above policy regarding my financial responsibility to Primary Medicine, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Primary Medicine, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made to my insurance carrier.

Responsible Party Signature _____ Date_____

Print Name: _____

PRIMARY MEDICINE, LLC

Patient Acknowledgement and Consent for Use and Disclosure

Of Protected Health Information

I hereby give my consent for Primary Medicine and its affiliates, to use and disclose protected health Information (PHI) about me to carry out treatment, payment, and health care operations (TPO). * For complete information on Use and Disclosures, please see The Notice of Privacy Practices provided by Primary Medicine.*

I have the right to review the Notice of Privacy Practices prior to signing this consent and have been provided the opportunity to review it. Primary Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the attention of the Privacy Officer, at the office address.

By signing this form, I am consenting to allow Primary Medicine to use and disclose my PHI to carry out Treatment, Payment, and Healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Primary Medicine, may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name if Legal Guardian

_____ _____

Print Patient's Name Date

**For Office Use Only* I attempted to obtain the patients signature in acknowledgement on the Notice of Privacy Practices Acknowledgement and Consent, but was unable to do so as documented below:*

Date: _____ *Reason:* _____ *Initials:* ____