PATIENT REGISTRATION FORM

Patient Information

Last Name _____ First Name _____ M.I. _____

Marital Status _____ DOB _____ Sex_____ Occupation _____

Address _____ City _____ State _____Zip _____

Home Telephone _____ Work /Mobile Telephone _____ SSN _____

Employer Name and Address_____

_____Email _____

EMERGENCY CONTACT
Name_____ Phone#_____ Relationship: _____

I authorize Stewart Family Medicine to disclose my protected health information to the family member/individual listed below. Stewart Family Medicine may discuss:

- Medical information relating to my care
- Payment for medical services performed on my behalf
- Information relating to the start/end of my appointments

Disclosure is authorized for the following person (s):

1. Name _____ Relationship to Patient _____
2. Name _____ Relationship to Patient _____
3. Name _____ Relationship to Patient _____
4. ☐ **I authorize disclosure to no one at this time**

Do you have an Advanced Directive? ☐YES ☐NO
If yes, please provide a copy to our office within 30 days from today's date.
(Note: If copy not provided as directed, Stewart Family Medicine shall not be liable for the contents of any advanced directive.)

Would you like information on Advanced Directives? ☐**YES** ☐**NO**

WE WANT TO KNOW!

HOW DID YOU HEAR ABOUT US?

Please check one of the following:

☐ Referral? From whom?
_____

☐ Advertising? If yes, what medium?

- ❑Internet/Web Site
- ❑Insurance Co.
- ❑Tucker Times
- ❑Newspaper
- ❑Other

_____

Payment/Assignment of Benefits Confirmation

I understand that I am responsible for payment in full of all charges. I authorize that payment of benefits from my insurance be paid directly to Stewart Family Practice, P.C. (Referred to as Stewart Family Medicine). I also authorize Stewart Family Medicine to release to my insurance company any and all information necessary for the processing of insurance claims. If UNINSURED, payment for services is due at time services are rendered.

Signature _____ Date _____

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Patient Consent for Use and Disclosure of Protected Health Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among health professionals contributing to my care
- A source of information for applying my diagnosis to my bill
- A means by which a 3rd payor can verify that services billed were provided
- A tool for assessing quality and reviewing the competence of healthcare professionals

I hereby give my consent for **Stewart Family Medicine** to use and disclose PHI about me to carry out treatment, payment and health care operations hereafter referred to as TPO.

The Notice of Privacy Practices provided by Stewart Family Practice, PC describes such uses and disclosures more completely. I understand and have been provided with this Notice of Privacy Practices.

Patient Signature _____ Date_____
Witness/Legal Guardian _____ Date_____

*****Please check all that apply:**
☐Confirming the receipt of Privacy Practices ☐Patient Consent for Use & Disclosure of PHI

Financial Policy of Stewart Family Medicine

We no longer accept checks; Acceptable forms of payment are cash, debit or all major credit cards. Please let us know if you have any questions or concerns. **Please initial each line item, and sign/date upon completion:**

_____1. **Co-payments, co-insurance and deductibles.** These items must be paid at the time of the service and are part of your contract with your insurance company. Co-payment disputes should be settled with your insurer, not our office.
_____2. **Non-covered services.** Some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
_____3. **Proof of insurance.** We require a copy of your driver's license and current valid insurance. Failure to provide us with the correct insurance information may cause you to be responsible for the balance of a claim.
_____4. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
_____5. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 10 business days to pay your account in full or set up a payment plan (payable in 3 equal installments). Please be aware if a balance remains unpaid, we may refer your account to an outside collection agency.
_____6. **Missed appointments.** Our policy is to charge **$30** for missed appointments not canceled with at least 24 hours notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
_____7. **Forms and Medical Records Fees.** Our policy is to charge a nominal fee for the cost of **copying and mailing records** and **completing forms.** Fees for these services are due at the time services are requested. Please allow two weeks for forms completion and/or medical records processing.
_____8. **MVA (Motor Vehicle Accidents).** Our policy is to collect the full balance of any MVA accident visits. We will provide you with the documentation needed to file the claim with your auto or medical insurer for reimbursement.

PATIENT REGISTRATION FORM

I have read and understand the financial policy and agree to abide by its guidelines:
Patient Signature _____ Date_____