Patient Registration Form

LaMond family medicine

Patient Information:

Patient/Child First Name:_____ MI:_____ Last Name:_____

Age:_____ Date of Birth:_____ Occupation:_____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorced Soc. Sec. #:_____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Email address:_____ Drivers License #:_____

Previous Primary Care Provider:_____ **Referring Doctor**:_____

What pharmacy do you use for medication refills: _____ **Address:** _____

Parent/Guardian (REQUIRED IF PATIENT IS UNDER 21 YEARS):

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is NOT bound by any separation agreement, divorce or child support order.

Parent/Guardian:_____ Birth Date:_____

Address (if different from above):_____

Social Security # (required):_____ Employer: _____

Preferred Phone #: _____

In case of an emergency, who would you like to be contacted?

Contact Name:_____ Relationship to Patient:_____

Home Phone #:_____ Work Phone #: _____

HIPAA CONSENT: Below, please list anyone you would like to be allowed to receive information regarding your medical care (leave blank if you would not like any additional individuals to have information regarding your care).

1. _____ 2. _____

By signing, you agree the information above is correct and give permission for Lamond Family Medicine to file claims on your behalf as well as share your medical care information with the above listed contacts. *Without signed consent, we can NOT share information regarding your medical care (including family).*

Patient/Guardian Signature: _____ Date: _____

Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to LaMond Family Medicine.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment if necessary. Please allow 24 hrs for a response to refill requests. Samples are given at scheduled appointments ONLY and can ONLY be given by the doctor.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

Patient/Guardian Signature for Financial and Office Policies: _____

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature: (HIPAA Policy) _____ Date:_____

Health History

LaMond family medicine

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

List your prescribed drugs, over the counter medications and supplements

Name of Drug:	Strength:	Frequency Taken:

Personal Health History:

List any **medical problems** that other doctors have diagnosed:

Year:	Medical Problem:	Treatment/Medication(s): *(if prescribed)*

Allergies to medications:

Name of Drug:	Reaction:

Surgeries:

Year:	Type of Surgery:	Surgery Reason:

Health History (Continued)

Hospitalizations:

Year: Reason:

_____ _____

_____ _____

_____ _____

Family Health History: (Please comment on general, weight and psychiatric history)

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Father (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Mother (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Paternal Grandfather (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Paternal Grandmother (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Maternal Grandfather (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Maternal Grandmother (Please Circle) Alive Deceased Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Health History (Continued)

Siblings

Brothers _____ Enter Qty.

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Sisters _____ Enter Qty.

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Children

Son _____ Enter Qty.

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Daughter _____ Enter Qty.

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Health Habits

Exercise: (check your selection) ☐ Sedentary (no exercise) ☐ Lightly active (1-3 days per week)

☐ Moderately Active (3-5 days per week) ☐ Very Active (6-7 days per week)

☐ Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ None _____ # of cups/cans per day?

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____

How many drinks per week? _____ Are you concerned about the amount you drink ☐ Yes ☐ No

Have you ever used Tobacco? ☐ Yes ☐ No If yes, do you currently use tobacco? ☐ Yes ☐ No

Cigarettes (packs/day): _____ Chew (#/day): _____ Pipe (#/day): _____ Cigars (#/day): _____

# of years: _____ Year quit: _____

HIPAA

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I, _____, understand that as part of my health care, LaMond Family Medicine originates and maintains paper and/or electronic 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 communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Patient's Signature (authorized representative signing for the patient):

Signature: _____ Date: _____

By signing this document, I confirm that I fully understand and accept the terms of this consent.

FOR OFFICE USE ONLY:

Consent received by: _____ Date: _____

I further understand that LaMond Family Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the physicians at LaMond Family Medicine change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree, email).
I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.