Keating Family Medicine

Patient Registration Form

Name: _____ Sex: ____ M _____F

Patient's Social Security #: _____Date of Birth:_____

Home Phone: _____Work Phone:_____

Cell Phone: _____

Home Address: _____

City: _____Zip Code: _____

Email Address: _____

Marital Status (Circle One): Married Divorced Legally Separated Single

Whom may we thank for referring you:_____Phone: _____

Emergency Contact

Name:_____ Relation to Patient:_____ Phone:_____

Name:_____ Relation to Patient:_____ Phone:_____

Who may we thank for referring you?_____

Insurance Information

Name of Policyholder or Subscriber (if not patient): _____

Relationship to Patient: _____

Policyholder or Subscriber Date of Birth: _____

Insurance Company: _____

Member ID: _____

Group #: _____

Secondary Insurance Information

Name of Policyholder or Subscriber (if not patient): _____

Relationship to Patient: _____

Policyholder or Subscriber Date of Birth: _____

Insurance Company: _____

Member ID: _____

Group #: _____

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Please list ALL Current Medications

Name	Strength/Dose	Name	Strength/Dose
Name	Strength/Dose	Name	Strength/Dose
Name	Strength/Dose	Name	Strength/Dose
Name	Strength/Dose	Name	Strength/Dose

Pharmacy

Name	City/State	Phone

Payment and Collections

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

_____

Signature Date

_____

Guardian Signature (if patient is a minor) Date

We are contracted with a collection agency, to which we automatically send patients who have an outstanding balance of greater than 90 days. If you have an outstanding balance you must pay it before you can be seen again.

Signature: _____

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Consent for Treatment

- Permission is hereby given for any medical/surgical procedure, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, or Nurse Practitioner.
- In the case of an un-emancipated minor, the consent below is being given on his or her behalf.

Financial Responsibility

- Co-payments, deductibles, and private pay services will be collected during the check-in process.
- Charges for all minors are the responsibility of the parent, guardian, or individual PRESENTING the child for treatment.
- I understand a Social Security number is necessary to file insurance or collect information from my insurance company. If I choose to withhold it, I have the option of rendering payment in full at time of service and personally submitting a claim for reimbursement to my insurance company.
- I understand my insuranc ecompnaymay have an exclusive agreement with a specified laboratory for lab tests and that I recognize my responsibility to inform the staff of any arrangements prior to the performance of tests. Failure to notify staff may result in higher patient liability.
- It will be my responsibility to pay reasonable collection charges and/or attorney fees.

Acknowledgment of Privacy Rights

- By signing below I acknowledge that I have received Keating Family Medicine's notice of Privacy Practices and Individual Rights.

Identity Theft

- Keating Family Medicine has your protection in mind when asking for a copy of your Driver's License or a picture ID card. It is used to help protect your identity in preventing insurance fraud, to certify your identity for prescriptions and medical record release. In addition, it is needed for credit card and check verification.

Protected Health Information (PHI)

- If at anytime the following people contact Keating Family Medicine regarding my protected health information, they will be asked to identify himself/herself and will be asked to verify my date of birth.
- Anyone contacting KFM regarding my health that IS NOT ON THIS LIST WILL BE DENIED access to my PHI.

PHI Release

Name	Relation	Phone Number

Any additions or deletions to this form must be given to Keating Family Medicine in writing.

Print Name: _____ Signature: _____ Date: _____

Patient Name (if parent or guardian signature above): _____

Keating Family Medicine

Formulary Benefits Data Consent Form

Formulary benefits data are maintained for health insurance providers by organizations known as Pharmacy benefits Managers (PBM). PBM's are third party administrators of prescriptions drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for Keating Family Medicine to access my pharmacy benefits data electronically through RxHub. This consent will enable KFM to:

- Determine the pharmacy benefits and drug co-pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non0formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

In summary, we ask your permission to obtain formulary information, and information about prescriptions prescribed by other providers using RxHub.

_____ _____/_____/_____

Patient's Name (PLEASE PRINT) Date of Birth

_____ _____/_____/_____

Signature (Patient/Guardian) Date

Assignment and Release

I, the undersigned, have insurance coverage with the listed insurer(s) and assign directly to Keating Family Medicine all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to KFM. For any services furnished by that physician's supplier, I authorize the holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

Privacy Policy

it is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to you. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of your PHI to the highest degree possible. You should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment, and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use, and disclose PHI only in conformance with state and federal laws and current for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without your authorization.
- Use and disclose PHI to remind you of appointments unless we are instructed not to.
- Recognize that PHI collected from you must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:
  - Implement reasonable measures to protect the integrity of all PHI maintained.
- Recognize that you have a right to privacy. Our physicians and staff respect your individual dignity at all times. We will respect your privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential.
- Consequently, our physicians and staff will:
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless you (or your authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.
- Recognize the although our practice "owns" the medical record, you have a right to inspect and obtain a copy of your PHI. In addition, you have a right to request an amendment to your medical record if you believe your information is inaccurate or incomplete. Our practice and its physicians and staff will:
  - Permit access to medical records when your written request is approved by our practice. If we deny the request, then we must inform you so you may request a review of our denial. In such cases, we will have an on-site healthcare professional review appeals.
  - Provide an opportunity to request the correction of inaccurate or incomplete PHI in medical records in accordance with the law and professional standards.
  - Any medical records released to a physician's office may take up to 30 days as required by law. You may request a paper copy of your medical records, however you may be charged an administrative fee and a copying cost for the records based on the number of sheets in the copy. This must be paid in advance or when records are released to you.
- Our physicians and staff will maintain a list of all disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization. We will provide this list to you upon written request.
- Our physicians and staff will adhere to any restrictions concerning the use of disclosure of PHI that you have requested and have been approved by our practice.
- Our physicians and staff must adhere to this policy. We will not tolerate violations of this policy. Violations will result in disciplinary action up to and including termination of employment and criminal/professional sanctions in accordance with our personnel rules nad regulations.
- We may change this privacy policy in the future. Any changes will be effective upon release of a revised privacy policy and a copy will be made available to you upon request.