Today's Date _____/_____/_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow

Is this your legal name? □ YES □ NO	If not, what is your legal name?	Birthdate / /	Age Sex □ M □ F □ T

Street Address City State Zip Code	Home Phone Number ( )

Cell Phone Number ( )	**E-Mail Address**	Social Security - -

Occupation	Employer	Employer Phone Number

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Do you have a living will? □ YES □ NO

Pharmacy:

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION **(information used for patient balance statements)**

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials.

_____ _____

Patient/ Guardian Signature Date

Sumner Station Family Wellness

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at _____. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at_____. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

8. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

Sumner Station Family Wellness

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I acknowledge receipt of the Notice of Privacy Practices.

_____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient (if other than patient) _____

☐Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness _____
Printed Name- Practice Representative

Witness _____ _____
Signature Date

SUMNER STATION FAMILY WELLNESS
HIGHPOINT HEALTH PARTNERS

G. Summers Chaffin, MD Stephen E. Sharpe, PA-C Terry L. Witherington, DNP, APRN Amanda Barton FNP-C, APRN

I, authorize _____ Provider Phone # _____

Medical Office _____

Address _____ Provider Fax # _____

City, State, Zip _____

To release health medical information of:

Patient's Full name _____ DOB _____

This information is to be released to:

Sumner Station Family Wellness, HighPoint Health System
225 Big Station Camp Blvd., Suite 206
Phone 615-328-3400 FAX 615-328-3416

For the purpose of:

____ Permanent transfer to new provider
____ Continuity of medical care
____ Insurance of other third party reimbursement
____ Other (Specify) _____

This release includes specifically (circle all that apply)

Office Notes	Laboratory Reports	Complete Medical Records
Radiology/Reports	History and Physical	EKG

Other _____

Covering records from:

1) The person from _____ to _____

2) Date(s) of Service _____

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1) I acknowledge and hereby consent to such that the release of information may contain information regarding alcohol, drug abuse, psychiatric, HIV testing, AIDS, or other sensitive information _____ (initials of pt)
2) I may refuse to sign the authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exam, or drug screenings
3) I may revoke this authorization at any time in writing, but if I do, it will not have any affect or actions taken prior to receiving the revocation. Further details may be re-disclosed.
4) If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5) I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
6) I will receive a copy of this form after I sign it or a copy will be maintained in my permanent record.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Rep Date:

_____ _____

SUMNER STATION FAMILY WELLNESS
HIGHPOINT HEALTH PARTNERS

G. Summers Chaffin, MD Stephen E. Sharpe, PA-C
Terry L. Witherington, DNP, APRN Amanda Barton FNP-C, APRN

HIPAA RELEASE

I, _____ Date of Birth: _____

Authorize Sumner Station Family Wellness to release my medical information to:

_____ on my behalf.

Patient Signature: _____ Date: _____