Pinellas County Primary Care
AND HOSPITALISTS

Patient Registration Form:

Patient Information:

Name:_____ **Preferred Name:**_____

DOB: _____ ☐ **Female** ☐ **Male** **SSN:**_____

Primary Phone:_____ **Type:** ☐ **Home** ☐ **Cell** ☐ **Work**

Marital Status: _____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Primary Language: _____

Primary address: _____

City**:**_____ State:_____ Zip:_____

Secondary Address: _____

City**:**_____ State**:**_____ Zip**:**_____

Alternative Phone**:**_____ **Type:** ☐ **Home** ☐ **Cell** ☐ **Work**

Employment Information

Employment Status**:**_____ Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Phone**:**_____ Ext**:**_____

Personal Email*:_____Preferred method of notification:

Personal Email is required for access to our patient portal

Type: ☐ **Phone** ☐ **Email**

Additional Patient Information:

Primary care physician:_____

Person Financially Responsible:_____Relationship:_____

Emergency Contact:_____
Relationship:_____ Contact Phone:_____
Emergency Contact:_____
Relationship:_____ Contact Phone:_____

How did you hear about us?_____

Pinellas County Primary Care
AND HOSPITALISTS

Patient Registration Form:

Insurance Information:

Primary:_____ Secondary:_____

Policy Holder ID:_____ Policy Holder ID:_____

Policy Holder Name:_____ Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder DOB:_____

Relationship to Policy Holder:_____ Relationship to Policy Holder:_____

Policy Holder Sex: ☐ Female ☐ Male Policy Holder Sex: ☐ Female ☐ Male

Co-Payment amount:_____ Pharmacy:_____

Address:_____

Phone:_____

Extended Information:

Do you have a visual impairment that will prevent you from reading written material from your Doctor?

☐ Yes ☐ No

Do you have a hearing impairment that will complicate spoken communication with your doctor? ☐ Yes ☐ No

Have you seen a specialist since your last visit with your primary care doctor? ☐ Yes ☐ No

If yes, please indicate the name of the provider(s) below:
Provider:_____

Provider:_____

Patient Signature:_____

Printed Name:_____

Date: _____

Pinellas County Primary Care
AND HOSPITALISTS

I

Uses and Disclosures of YOUR Protected Heath Information (PHI)

understand that as part of my heath care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test records, 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 health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures.

Tell us with whom may we discuss your PHI: Protected health information: Name and relation – Ex: Jane Doe- Wife; Jon Doe- Son)_____

Messages or Appointment Reminders

Messages will be of a non-sensitive nature, such as, appointment reminders

May we leave a message on your voice mail using doctor's/practice name? ☐ Yes ☐ No

May we leave a message with another individual using doctor's/practice name? ☐ Yes ☐ No

May we leave a message at your work using doctor's/practice name? ☐ Yes ☐ No

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, EX: referrals to other health care providers. I understand that my information may be used or disclosed, without an authorization, as permitted or required by law.

_____ _____

Patient/ Guardian Signature Date

_____

Print the name of the person signing

If other than the patient: (Print Patient Name)_____ is signing, are you the legal guardian, custodian, or have Power of Attorney(POA) for this patient, for treatment, payment or health care operations? ☐ Yes ☐ No

Pinellas County Primary Care
AND HOSPITALISTS

Patient Consent:

Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary at advisable in the judgement of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions or the patient's physician. Pinellas County Primary Care has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to Pinellas County Primary Care of any insurance benefits otherwise payable to me for me for services, at a rate not to exceed Pinellas County Primary Care regular charges for such services.

Releasing Medical Information

I understand that Pinellas County Primary care, its business associates, any treatment physicians/surgeon and/or my insurance company may obtain, use and/or disclose information for the purpose of treatment, payment and normal health care operations. The use and disclosure may include collection agencies and credit bureaus. Information mat include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the facility and other health care providers will be unable to bill my insurance company other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implanted devices consent to release of their social security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review Pinellas County Primary Care's Notice of Privacy Practices.

Permission for Treatment

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical surgical treatment as is deemed necessary.

The undersigned certifies that he/she had read the forgoing, received a copy thereof and id the patient or is duly authorized by the patient's general agent to execute the above and accepts its terms.

Patient:_____

Please PRINT name

Signature of Patient or Authorized Person:_____

Relationship:_____ Date:_____

Witness Signature: _____ Date:_____

If the Patient did not sign, please state reason: _____

_____

Pinellas County Primary Care
AND HOSPITALISTS

Financial Agreement

We are participating providers for Medicare, as well as many HMO & PPO plans. We will file claims on your behalf. You will be responsible for all balances, copays & deductibles, per your insurance explanation of benefits. You are responsible, as the insured & the patient, for providing our office with a copy of your current medical insurance. If you do not inform us of any changes, or provide us with correct information, you will be responsible for charges incurred. Payments (copay & deductibles) are due at the time of service. We accept cash, checks, Master Card, Visa & American Express. For any checks returned for non-sufficient funds, will result in a $25 fee.

Referrals & Authorization

This office requires a minimum 5-7 business days to process routine authorization requests. If applicable, you are responsible to ensure that any insurance referrals and/or authorizations are obtained prior to your visit, or procedure by a specialist. Short (less than 5-7 business days), or no notice from you, may result in canceling or rescheduling your appointment with the specialists.

Notice of "Non-Covered" Services

I am aware that some services performed by the practice may be considered "non-covered "by my insurance carrier, or Medicare, therefore, I will become financially responsible for payment of these services.

Notice of Missed Appointment Fee

Our office requires 24 business hours to cancel or reschedule. Failure to provide the required 24-Business hours notice, will result in a **$35 fee. Any missed appointment fees must be paid prior to being seen.**

This office provides sign language interpreters for those in need. However, please be aware, if you do not show up or cancel within 24 business hours of your scheduled appointment, you will be responsible to pay for the minimum fee assed by the interpreter. **(The fee may vary by interpreter, typically around $140- If you incur this fee, it must be paid to our office, prior to rescheduling the missed appointment.)**

Collections Policy

Should your account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection & attorney fees for collection expenses in addition to any outstanding bills.

Patient's name (PRINT) _____ Date_____

Signature of Patient (or legal guardian-if legal guardian, relationship to the patient_____)

X _____