**HIPAA**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list below any person(s) WRFH may contact (by checking the box) if we may discuss any information related to your **billing account** and/or **medical conditions**. Also, choose the person you would like us to list as your **emergency contact** in the event an emergency situation was to take place at our office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Billing □ Medical Information □ Emergency Contact

Name Relationship Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Billing □ Medical Information □ Emergency Contact

Name Relationship Phone

DO NOT disclose or discuss any information related to my billing account or medical conditions with anyone other than myself, except in an emergency situation.

* **I do not wish** to be notified by any other communication method requarding my medical conditions. I request that communication regarding my medical conditions to occur **ONLY** when I am in the clinic.

**My preferred method of communication regarding my medical condition is indicated below (check one):**

Home Phone  Work Phone Cell Phone  Mailed Letter  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the above method of communication is by phone, please check the appropriate box below:**

 OK to leave a message with detailed information.  Please leave a message with a call back number only.

**Use of Electronic Communication from WRFH to the patient**

* Yes, I want WRFH to communicate my information with me through WRFH patient portal.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* No, I **do not** want WRFH to use electronic communication as a way to communicate my information to me.

**Prescription History Consent**

I authorize White Rock Family Health and its affiliated providers to access and use my prescription history for treatment

purposes. Prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit

managers may be viewable and it may include prescriptions dating back for several years.

I acknowledge that White Rock Family Health may use health information exchange systems to electronically transmit,

receive and/or access my prescription history.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require authorization prior to the disclosure of any medical information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient, Parent or Legal Guardian Relationship to Patient

**New Patient Registration**

How did you hear about the physician you are seeing today?

□ Family/Friend □ Hospital □ Internet/Website □ Physician Referral □ Insurance □ Location/ Drive By □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language

Race

□ American Indian or Alaska Native □ Black or African American □ White □ Asian □ Multiracial □ Decline □ other

Employment Status (check one)

□ Full-time □ Part- time □ Student □ None

Spouse’s Name (If Applicable)

s

Marital Status (check one)

□ Single □ Married □Divorced □ Widowed

Driver License #

Social Security #

Date of Birth

Cell Phone #

Work Phone #

Home Phone #

Zip

State

City

Address:

Middle

First

Patient Name: Last

AA

jh

Ethnicity

□ Hispanic □ Latino □ Decline

I hereby authorize employees and agents of White Rock Family Health, including physicians, nurse practitioners and other employees to render medical evaluations and care.

I hereby authorize payment of medical benefits directly to White Rock Family Health and/or the physician for services rendered. Authorization is hereby granted to release information contained in the patient’s medical record to the patient’s insurance company (or its employees or agents) as may be necessary to process and complete the patient’s medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (“AIDS”) and Human Immunodeficiency Virus (“HIV”). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient’s insurance company.

The Health Insurance Portability and Accountability Act (HIPPA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.The Notice of Privacy Practices is displayed for review and I understand that I am entitled to receive a copy of this document.

Payment is due at the time of service and will be collected during the check in process. We accept cash, check and credit card. Valid government photo identification is required for all transactions. A $35.00 fee applies to for returned checks.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Legal Guardian Date

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Legal Guardian Date

**Complete this section ONLY if patient is a minor**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian Date

Phone

Policy ID Number Group ID

Primary Insurance Company

Sex (check one)

□ Male □Female

Claims Address

Employer

Responsible Party: Last

Date of Birth

Social Security #

**Complete this section only if the patient is a minor**

Relationship

First

Pharmacy Name:

Pharmacy Phone #