Patient Registration Form

RossLegacy MEDICAL GROUP

PLEASE FILL IN COMPLETELY THANK YOU

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Date of Birth:

Sex: ☐ Male ☐ Female | Social Security #: | Marital Status: | Employment Status:

Preferred Language: | Email Address:

Mailing Address: | Apt # | City/State/Zip:

Home Phone: | Cell Phone: | Work Phone: | Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Preferred Method of Contact for reminder calls and other electronically generated messages ☐Voice ☐Text

Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Emergency Contact Name:	Emergency Contact Phone #:
Insurance Policy Holder Name:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Patient Relationship to Policy Holder:

Additional Information and Responsible Party

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Smoking Status: **Please Circle: Current Every Day, Current Some Day, Former Smoker, Current Smoker, Never Smoked**
If Smoker Frequency:

Family Physician or Pediatrician Name and Phone:

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Hispanic ☐ Black or African American ☐ Indian (including Hindi & Tamil)
☐ Other ☐ Decline ☐ Russian ☐ Other

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Pharmacy Name, Location, and Phone Number:

Responsible Party- PLEASE COMPLETE If the patient is a minor (under the age of 18),

Last Name:	First Name:
Date of Birth:	Phone:
Social Security #:	Relationship to Patient:

Address of Person Responsible:

Secondary Insurance

Secondary Medical Insurance Information

Staff Notes:

Ins. Co. Name	
Policy Holder Name:	
Policy Holder's Date of Birth:	
Policy Holder's Social Security #:	
Patient Relationship to Policy Holder:	

I have read and agree to Ross Legacy Medical Group's (RLMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to RLMG all money to which I am entitled for medical expenses related to the services performed from time to time by RLMG, but not to exceed my indebtedness to RLMG. I authorize RLMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Ross Legacy Medical Group is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Karl Gebhard, MD, APC, dba Ross Legacy Medical Group. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Ross Legacy Medical Group's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**

Ross Legacy Medical Group DATE:__/___/__

NAME:_____DOB:_____

MEDICAL HISTORY

PAST MEDICAL PROBLEMS:

DIABETES ASTHMA HIGH BLOOD PRESURE HEART DISEASE COPD/ EMPHYSEMA
HIGH CHOLESTEROL DEPRESSION
OTHER:_____

PAST SURGICAL HISTORY:

TONSILECTOMY APPENDECTOMY GALL BLADDER REMOVAL
CARDIAC BYPASS SURGERY HERNIA REPAIR JOINT REPLACEMENT
OTHER:_____

WOMEN:

HYSTERECTOMY OVARIES REMOVED BREAST SURGERY

MEN:

VASECTOMY PROSTATE SURGERY

Do you or have you ever smoked or used tobacco products?
If so how many per day?_____ When did you quit?_____

Do you drink alcoholic beverages? How many per week?_____

HAVE YOU HAD ANY OF THE FOLLOWING? IF SO, WHEN?

TETANUS SHOT _____ PNEUMONIA VACCINE_____HEPATITIS A OR B VACCINES_____
MAMMOGRAM _____ COLONOSCOPY _____ CARDIAC STRESS TEST_____

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY HAD OR HAS?

__ *Diabetes* __ *Prostate Cancer*

__ *Heart Disease* __ *Other Cancer:* _____

__ *High Cholesterol* __ *Other Issues:*

__ *Hypertension* _____

__ *Breast Cancer* _____

__ *Colon Cancer* _____

Ross Legacy Medical Group

Patient Partnership Plan

Dear Patient,

Welcome to Ross Legacy Medical Group. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health" we ask you to help us in the following ways:

1. Take responsibility for scheduling and attending follow-up appointments (as recommended). Depending on your individual medical condition, failure to comply with a follow-up may cause your condition to retrogress. Even if you are not due for a follow-up visit, but you have a concern regarding your condition, feel free to call the office for an appointment.

2. Assist our office in obtaining and communicating the results of your ordered diagnostic studies and other services. We will determine and communicate to you which studies are appropriately required for optimizing your medical treatment, and we will do our best to obtain and communicate those results to you in the timeliest manner. However, it is your responsibility to comply with these orders, and also we ask that you assist us in ensuring that these results are received. In the event that your results are not obtainable (either for patient privacy reasons, or other reasons, etc.), we may ask that you participate in obtaining these results directly from the facility/entity which has provided the testing service.

3. Assist our office in obtaining the appropriate authorization(s) for the delivery of medical services and products. Depending on your individual insurance coverage, certain services or products (i.e. splints, etc.) may require special pre-certification. Please be patient if our office delays the delivery for certain services and/or dispensing of products due to pending prior-authorization. We may ask that you contact your insurance representative, and/or primary healthcare provider to help expedite the pre-certification process.
4. Communicate your decision to follow, or to NOT follow, our "Recommended Treatment Plan." Based on your individual medical condition, recommendations will be made regarding which treatment course is best for you. This may, or may not, include prescribing medication, ordering further diagnostic evaluations, conservative observation versus surgery, therapy, or referring you to another physician/specialist. If you do not agree with the treatment plan recommended, or you change your mind after having been seen, please communicate your decision to us. If you fail to do so, our office will not be able to advise you of any associated risks or consequences which may result from your decision to delay or refuse treatment. Lastly, we want you to know that as our patient, you have the right to be fully informed of your medical condition and the care associated. We encourage you to ask questions, report symptoms, and discuss any concerns you have regarding your care. We look forward to servicing you, and once again, welcome to our office and thank you for your participation.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Physician Signature

Ross Legacy Medical Group

PAYMENT POLICY

It is the policy of Ross Legacy to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card is required and must be presented before services are rendered. Enrollment in an insurance plan is not a guarantee of payment. Deductibles, co-payments and patient responsibility are due at time of service.
Ross Legacy does not assume responsibility for verification of insurance benefits and/ or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan *BEFORE* services are rendered.

Any portion of the balance that is not paid by the insurance company due to patient co pays or deductible amounts, non covered services, deemed by the insurance company as not medically necessary, doctor non participating in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party.

If a statement of charges needs to be sent to the patient you can:

☐ Opt -in to enroll in Office Ally Patient Portal. You will receive an email with balance due.

This option is free of charge. Please note, if multiple statements are emailed an additional

fee of 20.00 a month will incur every month there after until balance is paid in full.

Email_____

☐ Opt- out of Patient Portal services. Which will automatically result in a $15.00 fee per statement, per month. This fee is in addition to the balance owed. The fee is non-negotiable. Delinquent balances maybe referred to an outside agency for collection.

I have read the above policy and understand that I am financially responsible for all medical services rendered.

X_____Signature of patient or responsible party

X_____Print Name Date:

PPO MDCR PROVIDER_____ DATE:

HMO_____PCP: Intake Form TIME CHART UP TIME ROOMED

NAME : ADDRESS_____

D.O.B: AGE: _____

I would like to focus on these issues at today's visit:

List any medicine changes since your last visit:

What Pharmacy do you use?

List any tests or consultations since your last visit:

☐ **Preventive Exam (Health Screening):**

Diagnosing and treating a medical condition or illness, either acute or chronic is not part of a preventative exam. An office visit may be billed. Please see front office staff for further information.

What number and email may we use to contact you?

Phone: _____ (Cell preferred)

Email: _____

Who is your health insurance company?

My Family History (Parents, Brothers, Sisters):

__ **Diabetes** __ **Prostate Cancer**
__ **Heart Disease** __ **Other Cancer: _____**
__ **High Cholesterol** __ **Other Issues:**
__ **Hypertension** _____
__ **Breast Cancer** _____
__ **Colon Cancer** _____

Other issues today (check those that apply):

__ **Prescription Refills** __ **Mammogram**
__ **Referral** __ **Labwork**
__ **Note for work or school** __ **Vaccinations**
__ **Schedule for annual health screening exam**

**********FOR STAFF USE ONLY**********

_____ **Height**
_____ **Weight**
_____ **BMI**
_____ **Blood Pressure**
_____ **Temperature**
_____ **Pulse**
_____ **O2 Saturation**

Smoke/Chew: Never Currently Previously

Pack years_____Year quit_____

DM Distal Exam

Pharmacy:_____

LOCATION: _____

MA Initials: _____

Allergies:

Medications:

Services Provided:

LMP_____
FEMALE PRESENT
GC/CHL