PATIENT REGISTRATION FORM

NAME:_____ ADDRESS:_____

CITY, STATE, ZIP:_____ DATE OF BIRTH:_____ Driver License: _____

SOCIAL SECURITY #:_____ TELEPHONE #:_____

WORK #:_____ EXT._____ CELL PHONE #:_____

Employer: _____ OTHER #: _____

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐ MALE ☐ FEMALE

SPOUSE:_____ CELL PHONE: _____

PLEASE - Give your insurance card(s) & Driver's License to the Receptionist at the Front Desk

PATIENT RECORD OF DISCLOSURES – HIPAA AUTHORIZATION

I wish to be contacted in the following manner (Check all that apply) – using the numbers written above

☐ Home (◯) leave a message with detailed information
(◯) leave message with call back number only

☐ Written Communication (◯) mail to my home address
(◯) mail to my work address
(◯) Send any HIPAA information to my E-Mail thru Pt Portal

☐ Work Telephone
(◯) leave a message with detailed information
(◯) leave message with call back number only
(◯) Text Appointment Scheduling request

☐ Cell Telephone * I am fully aware a cell phone is not a secure line.*
(◯) leave a message with detailed information
(◯) leave message with call back number only
(◯) Text Appt Confirmation (◯) Text Additional Info

Email: _____ You will need a user ID and password to retrieve.

Please list your emergency contacts / family members or others that we may speak to regarding your healthcare.

NAME:_____ TELPHONE#:_____

NAME:_____ TELPHONE#:_____

CONSENT & AUTHORIZATION FOR TREATMENT & NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I consent to services, treatment and diagnostic procedures, including but not limited to medications, lab tests and other studies, which may be ordered by my physician, and consultants as selected by my physician. I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made with the financial department. By signing this consent, I assign all rights, title and interest and authorize direct payment to Golden Triangle Family Care Center of any insurance benefits or benefits under the Social Security Act for the services. Golden Triangle Family Care Center will assist in the billing of my insurance company, but I am financially responsible for charges not collected by this assignment. I authorize Golden Triangle Family Care Center to bill my insurance or third-party payor and receive payment from them. I acknowledge and consent that to the extent necessary to determine liability for payment or to obtain reimbursement, Golden Triangle Family Care Center may disclose my records including information that may be protected by HIPPA to any person, social security administration, insurance or benefit payor, health care service or plan which is or may be liable for all or any of the charges. Furthermore, Golden Triangle Family Care Center may disclose my records to other treating physicians, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies. I have been informed that this provider will keep my information confidential within the guidelines of HIPPA. My signature acknowledges that I have been given the right to ask questions and receive information about the services and I voluntarily sign this consent. I have been informed that I have the right to request an opportunity to review my chart, ask questions about my medical treatment and obtain copies at a reasonable fee. This authorization will remain valid for a period of one year unless I revoke it in writing. A photocopy of a faxed copy of this authorization shall be deemed as valid as the original. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications. I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signed: _____ Relationship: _____ Date:_____
To patient