

HILLIARD FAMILY MEDICINE PATIENT REGISTRATION

Patient Information

PLEASE PRINT

Name _____ Home Phone _____
Address _____ Birth Date _____ Sex M or F _____
City _____ State _____ Zip _____ Social Security # _____

Patient's Employer

Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Ext. _____

Spouse or Responsible Party Information

Name _____ Relationship To Patient _____ Birth Date _____
Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Spouse's Social Security # _____ Work Phone _____ Ext. _____

Primary Insurance

Secondary Insurance

Company _____ Company _____
Address _____ Address _____
Group # _____ Group # _____
Subscriber _____ ID# _____ Subscriber _____ ID# _____

Others In Household

Name _____ Relationship To Patient _____ Birth Date _____ Age _____
Name _____ Relationship To Patient _____ Birth Date _____ Age _____
Name _____ Relationship To Patient _____ Birth Date _____ Age _____
Name _____ Relationship To Patient _____ Birth Date _____ Age _____
Name _____ Relationship To Patient _____ Birth Date _____ Age _____

Emergency Contact Person

Name _____ Relationship To Patient _____ Phone # _____
Referred to our office by _____ Today's Date _____

CONSENT FOR MEDICAL CARE

Permission is granted to the physicians and employees of Hilliard Family Medicine, Inc. to do such procedures as may be necessary to diagnose, treat, and care for the needs of myself, or of my dependent.

FINANCIAL RESPONSIBILITY

I agree to pay Hilliard Family Medicine, Inc. accounts on myself and/or my dependent for the services rendered when they are presented to me.

If I have medical insurance on myself and/or my dependent, I hereby authorize those benefits to be paid directly to Hilliard Family Medicine, Inc. I will pay all co-payments to the receptionist prior to my appointment. I understand that I am responsible for any balance that the insurance does not cover.

Accounts can be conveniently paid by CASH, PERSONAL CHECK, or CREDIT CARD.

There is a service charge of \$25.00 on all checks returned for insufficient funds.

I am responsible to notify this office of any insurance changes, including change of primary care providers. I will notify this office of address and phone number changes.

RELEASE OF INFORMATION FOR BILLING

I authorize Hilliard Family Medicine, Inc. to release any medical information that may be necessary for processing my insurance claim to my insurance company.

Patient Name: _____ Date: _____
(Please Print)

Signature of Responsible Party or Guardian: _____

Assignment of Direct Payment to
Hilliard Family Medicine, Inc.: _____

Witness: _____

(NOTICE TO INTERNET USERS: If printing this form from our website, please sign this page in the presence of Hilliard Family Medicine employees at the time you deliver your registration forms for processing. Thank you!)

**Consent Form
Hilliard Family Medicine, Inc.**

I consent to the use or disclosure of my protected health information by **Hilliard Family Medicine, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Hilliard Family Medicine, Inc.** I understand that diagnosis or treatment of me by the staff of **Hilliard Family Medicine, Inc.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Hilliard Family Medicine, Inc.** is not required to agree to the restrictions that I may request. However, if **Hilliard Family Medicine, Inc.** agrees to a restriction that I request, the restriction is binding on **Hilliard Family Medicine, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Hilliard Family Medicine, Inc.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Hilliard Family Medicine, Inc.'s Notice of Privacy Practices prior to signing this document. The Hilliard Family Medicine, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Hilliard Family Medicine, Inc. The Notice of Privacy Practices for Hilliard Family Medicine, Inc. is posted in the reception room of Hilliard Family Medicine, Inc. and on the Hilliard Family Medicine, Inc.'s website at www.hilliardfamilymedicine.com. This Notice of Privacy Practices also describes my rights and the Hilliard Family Medicine, Inc.'s duties with respect to my protected health information.

Hilliard Family Medicine, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Hilliard Family Medicine, Inc.'s website, by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Birth Date

Social Security Number/Account Number

Date