Established Patient Registration Form Ages 18 and up (REV. 08/2021)

PLEASE PRINT

Patient Name_____DOB_____ Age_____
SS#_____ Race_____Ethnicity_____ Male ☐ Female ☐
In State Address_____City_____State___Zip_____
Out of State (If Applicable) Address_____City_____State___Zip_____
E-mail _____
Alternate Number _____ Phone_____

In Case of Emergency

Name_____ Relationship to Patient_____
Address_____City_____State_____Zip_____
Home Phone_____ Work Phone_____

Consent of Treatment and Policies

PLEASE INITIAL BELOW AS AN INDICATION THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

_____ I understand each adult that wishes to be in the examination room must present ID and must be listed as an authorized adult. I also understand that all ID's will be scanned for the strict purpose of identifying within the practice and will not be released to an external source.

_____ I understand that I will be required to provide a state ID or a valid drivers license and a Health Insurance Card at the beginning of every visit. If I fail to do so, I understand my appointment may be rescheduled.

_____ I understand that it is my responsibility to fill out the "confidentiality release" form and keep it updated.

_____ I understand that this is a transition period and it is my responsibility to find an internal medicine doctor before my 19th birthday. I also understand Merchant Pediatrics does not see patients 21 and over.

Consent of Treatment

I have the legal right to give consent to the Physicians of Merchant Pediatrics to treat myself. I also give the physicians of Merchant Pediatrics consent to retrieve medication history from third party sources. I understand this consent will be valid during the entire term of care; furthermore, I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of examinations. I also understand my photo will be taken for the strict purpose of identifying within the practice and will not be released to external sources.

Patient Name (Print)_____ Patient's Signature_____
Date_____

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Office Policies and Procedures

PLEASE INITIAL BELOW AS AN INDICATION THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO ALL THE POLICIES CONTAINED ON THIS PAGE.

Patient Name:_____D.O.B_____

Payment Policy

_____ Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment.

Cancellation Policy

_____ Time has been specifically reserved for your appointment or treatment. Please call at least 24 hours prior to your appointment if you need to cancel your appointment, if not you will incur a $25 penalty fee.

Medical Record Fees

_____ + HRS 680 (Blue Immunization Form), HRS 3040 (Yellow Physical Form), and Forms for College or Military please note, fees may apply.

+Copies of Medical Records: $1 per page up to 25 pages, $0.25 each additional page thereafter.

Please Note: We have 30 days to process any medical release request. An additional fee will be charged if copies are required sooner.

+ Medical Disability/FMLA Form Completion: $25 per set of forms.

+ Notary available upon request, fees may vary.

Deductible

_____ If your deductible has not been met for the calendar year, Merchant Pediatrics charges a fee of $50.

Outstanding Balance

_____ If you have a previous outstanding balance, you are responsible for the balance. Full payment is expected in a timely fashion, but no later than 30 days from the receipt of your statement.

Assignment of Insurance Benefits

_____ I hereby authorize direct payment of medical benefits to Merchant Pediatrics for services rendered by the physicians or organization; I understand that I am responsible for any balances not covered by insurance.

Authorization to Release Information

_____ I hereby authorize Merchant Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

Insurance Signature Authorization Lifetime

_____ certify that the information given by me in the applying for payment under title XVIII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or its intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies; I permit a copy of this authorization to be used in place of the original

Managed Care Patients

_____ I am aware that it is my responsibility to know and understand the terms and conditions of my insurance policy. I will not hold the staff of Merchant Pediatrics responsible if I do not follow through in obtaining appropriate authorization; in this event I will bear the full responsibility of the services rendered.

_____

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Health History

Patient Information:

Patient Name_____ D.O.B_____ Age_____ ☐Male ☐Female
Home Phone_____ Cell Phone_____ Emergency Phone_____
Mother/Guardian_____ D.O.B:_____ Phone #_____
Occupation_____
Father/Guardian_____ D.O.B:_____ Phone #_____
Occupation_____

Do you:

Drink Alcohol? ☐Yes ☐No

Smoke Tobacco? ☐Yes ☐No
(if yes), packs per day_____
have you ever attempted to stop ☐Yes ☐No

Engage in Sexual Activity? ☐Yes ☐No (if yes), which form of protection do you use_____
Use Recreational Drugs? ☐Yes ☐No (if yes, please list)_____

Medical History:

Have you had any of the following? If yes, please specify
Specific allergies ☐Yes ☐No _____
Hospitalizations ☐Yes ☐No _____
Serious injuries ☐Yes ☐No _____
Major illnesses ☐Yes ☐No _____
Surgeries ☐Yes ☐No _____

Have you experienced difficulty with any of the following?

☐Head	☐Eyes	☐Nose & Throat	☐Blood Disorders	☐Rubella	☐Bronchitis or Cough
☐Lungs	☐Ears	☐Heart	☐Nervous System	☐Chicken Pox	☐Digestive System
☐Skin	☐Mouth	☐Urination	☐Measles	☐Muscles & Bones	☐Pneumonia
☐Asthma	☐Anemia	☐Mumps	☐MRSA		

Has there been a family history of?

☐Diabetes	☐Tuberculosis	☐Hay Fever	☐HIV/AIDS
☐Heart Disease	☐Cancer	☐Kidney Disease	☐Thyroid Disease
☐Convulsions	☐Asthma	☐Genetic Defects	☐Other_____

TB Risk: (PLEASE ANSWER ALL OF THE FOLLOWING)

1. Have you been in contact with a person with confirmed or suspected tuberculosis? ☐Yes ☐No
2. Have you ever had a Tuberculosis test done in the past? ☐Yes ☐No
   If yes, was the test positive? ☐Yes ☐No
3. Have you immigrated from Mexico, Haiti, Asia, Africa, South American or the Middle East? ☐Yes ☐No
4. Do you live with a person who either immigrated or traveled from Mexico, Haiti, Asia, Africa, South American or the Middle East? ☐Yes ☐No
5. In the last 3 months have you or any one living in the home had any of the following: (If Yes, please circle)

   ☐Yes ☐No (Chronic cough coughing blood night sweats weight loss excessive diarrhea)

6. Have you been exposed to a person that is HIV positive, or has a compromised immune system, homeless, resident of a nursing home, institutionalized, is or was incarcerated, drug user, or migrant farm worker?
   ☐Yes ☐No

Doctor Merchant PEDIATRICS Established Patient Registration Form Ages 18-and up (REV. 08/2021)

Confidentiality Release Form

Please read the following carefully before answering the questions. Please note you must sign either section A or section B, **PLEASE DO NOT SIGN BOTH.**

At Merchant Pediatrics, we want to offer a safe environment, which includes protecting your privacy. Please fill out Section A if you wish to add an authorized adult to communicate or collect information on your behalf. Please note that any adult listed must present a valid state ID or drivers license and will be kept on file.

Section A

Name:____________ Relationship____________ Phone Number____________ (Staff Only: ID Scanned ☐**Yes** ☐**No)**	**Are we allowed to release medical information to this person? (including diagnosis, lab, and x-ray results) ☐Yes ☐No** **Is this person authorized to make appointments, ask for refills, and request referrals on your behalf? ☐Yes ☐No** **Is this person allowed in the examination room with you? ☐Yes ☐No**
Name:____________ Relationship____________ Phone Number____________ (Staff Only: ID Scanned ☐**Yes** ☐**No)**	**Are we allowed to release medical information to this person? (including diagnosis, lab, and x-ray results) ☐Yes ☐No** **Is this person authorized to make appointments, ask for refills, and request referrals on your behalf? ☐Yes ☐No** **Is this person allowed in the examination room with you? ☐Yes ☐No**
Name:____________ Relationship____________ Phone Number____________ (Staff Only: ID Scanned ☐**Yes** ☐**No)**	**Are we allowed to release medical information to this person? (including diagnosis, lab, and x-ray results) ☐Yes ☐No** **Is this person authorized to make appointments, ask for refills, and request referrals on your behalf? ☐Yes ☐No** **Is this person allowed in the examination room with you? ☐Yes ☐No**

Patient Name (Print)____________ Patient's Signature____________

Date________ (Staff use only) Witness by____________

Section B.

At this time I do not wish to list anyone. I will be the only contact.

Patient Name (Print)____________ Patient's Signature____________

Date________ (Staff use only) Witness by____________

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Notice of Privacy Practices

Our practice is committed to educating our patients about health care issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another health care provider that relates to treatment, payment and/or that identifies you as an individual.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Billing and Payment	Health Care Operations
Appointment Reminders	Patient Contact Information	Treatment Options
Health-Related Benefits and Services	Release of Information to Family/Friends	Disclosures Required by Law
Treatment Review by Specialist	Progress Report Requests by Insurance Carrier	

The following categories describe unique situations in which we may use or disclose your identifiable health information:

Public Health Risks Deceased Patients Military
Health Oversight Activities Organ and Tissue Donation National Security Inmates
Lawsuits and Similar Proceedings Serious Threats to Health or Safety Worker's Compensation
Law Enforcement Research Sale of Practice

What are your rights concerning your individually identifiable Health Information (IIHI)? You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential Communications	2. Requesting Restrictions	3. Inspection and Copies
4. Amendment	5. Accounting of Disclosures	6. Right to a Paper Copy of This Notice
7. Right to File a Complaint	8. Right to Provide an Authorization for Other Uses and Disclosures	

9. Right to Transfer Medical Records to another Provider(s).

I have read the short notice provided by the Merchant Pediatrics practice and have been informed of how to obtain more information regarding our Notice of Privacy.

_____	_____	_____
Signature of Patient	Patient Name (Print)	Date

Request a copy ☐Yes ☐No