



Patient Registration

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____
Mailing Address _____ City: _____ State: _____ Zip: _____
Phone Number: Primary _____ Work _____ Date of Birth: _____
Gender: Male Female Social Security #: _____ Marital Status: _____
Race: _____ Preferred Language: _____
Email address: _____ Primary Doctor: _____

GUARDIAN INFORMATION: IF CHILD IS 17 YEARS OR YOUNGER, OR LEGAL GUARDIAN:

Last Name: _____ First Name: _____ Middle Initial: _____
Mailing Address (if same as above leave blank): _____ City: _____ State: _____ Zip: _____
Phone Number: Primary _____ Work _____ Date of Birth: _____
Gender: Male Female Relationship to patient: _____

INSURANCE POLICY HOLDER INFORMATION

Primary

Insurance: _____ Subscriber ID#: _____ Group#: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Marital Status: _____
Relationship to the Patient: _____

Secondary (if applicable)

Insurance: _____ Subscriber ID#: _____ Group#: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Relationship to the Patient: _____

* **Emergency Contact:** _____ **Relationship:** _____
Phone #: _____

FLIP PAGE

Patient Consent for Services & Use and Disclosure of Protected Health Information

I CONSENT (AGREE) TO MEDICAL SERVICES: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I will ask for any information I want to have about my services and will make my wishes known to the practitioners and/or staff.

I hereby give my consent for Quality Health Clinic, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Quality Health Clinic, PLLC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Quality Health Clinic, PLLC has the right to revise this document at any time.

With this consent Quality Health Clinic, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as reminder cards and patient statements as long as they are marked "personal and confidential."

With this consent Quality Health Clinic, PLLC may send an email to my home or other alternative addresses, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Quality Health Clinic, PLLC uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions but if it does it is bound by this agreement.

I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Quality Health Clinic, PLLC may decline to provide treatment to me.

By signing below, I am confirming that I understand the information above and that I consent to the disclosures described.

Clinic Payment Policy

IF YOU ARE COVERED BY INSURANCE:

Our office is currently participating in Medicaid, Medicare as well as many local, state and federal insurance programs. You must present your insurance identification card at the time of visit. We will file the claims for you. However, you are responsible for the annual deductible and copayment as required by your insurance plan. We will require that you pay the copayment and annual deductible prior to your office visit. If you do not have your insurance card with you at the time of your visit, you will be considered a cash pay patient.

IF YOU ARE NOT COVERED BY INSURANCE:

We understand that many patients may not be covered by any type of medical insurance. In order for this clinic to keep costs reasonable while giving you excellent healthcare, payment is required at the time of services unless prior arrangements have been made. For your convenience, we take major credit cards, credit/debit cards, checks and cash. There is a \$50 fee for all returned checks. Returned checks must be covered within 10 business days or the patient may be denied future services from this clinic. If the check is not recovered within the required time, the patient is subject to be terminated from seeking health care within this practice. If a check is returned for nonsufficient funds more than once by a patient/guarantor, then payment will only be accepted by cash or credit card.

CREDIT AND COLLECTION POLICY:

At this time Quality Health Clinic, PLLC requires payment be made at the time of service unless prior arrangements have been made. We will do our utmost in keeping you informed of your healthcare costs as services are rendered. If there is a balance on your account after your insurance carrier has been billed, you will be responsible for payment on your account in a timely manner that will be noted on your invoice/statement. Balances not paid after 90 days will be subject to collection and legal services and health services from this clinic may be denied until the account is no longer delinquent. If balances are forwarded to collections, a 43% fee of your total bill, that was sent to collections, will be added to your account. This fee will need to be paid before any further services are rendered.

MISSED APPOINTMENTS:

In the event that you are unable to keep a previously scheduled appointment, it is our expectation that you will call the clinic prior to your scheduled appointment time. Otherwise the clinic reserves the right to charge your account \$50 which will need to be paid prior to scheduling additional appointments. By signing below, I am confirming that I understand the information above.

By signing this form, I certify that the information provided above is complete and accurate to the best of my knowledge.

Printed Name of Patient or Guardian

Signature of Patient or Guardian

Date