

PATIENT REGISTRATION FORM

Today's Date: _____ **Clinic Name:** _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone #: (_____) _____ - _____ Social Security #: _____
 Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ Drivers Lic#: _____
 Employer Name and Address: _____

 _____ Work Phone #: (_____) _____ - _____
 E-mail Address: _____ Cell Phone #: (_____) _____ - _____
 Emergency Contact Name: _____ Emerg Phone #: (_____) _____ - _____

Please tell us how you heard about us: _____

GUARANTOR INFORMATION: (List person responsible for bill -use full legal name, no nicknames)

Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____
 Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____

 City: _____ State: _____ Zip: _____
 Home Phone #: (_____) _____ - _____ Social Security #: _____

 Date of Birth: _____ Age: _____ Sex: Female _____ Male _____
 Employer Name and Address: _____

 _____ Work Phone #: (_____) _____ - _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

Plan Name : _____ Insured's Name: _____
 Insured's Social Security #: _____ Insured's Date of Birth: _____
 Policy / ID #: _____ Group #: _____ Eff Date: _____
 Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ Insured's Name: _____
 Insured's Social Security #: _____ Insured's Date of Birth: _____
 Policy / ID #: _____ Group #: _____ Eff Date: _____
 Claims Address & Phone: _____

Please read and sign back of form.



**MEDICALEDGE HEALTHCARE GROUP
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS**

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my army dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES

I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

(If different from patient)

GUARANTOR NAME (Please Print) _____



HEMATOLOGY ONCOLOGY PHYSICIAN EXPERTS

Bringing hope to cancer patients

v.11.2008

Name: _____

Date: _____

PATIENT HEALTH HABITS

Do you (or did you) smoke? _____ If yes: how much? _____ For how many years? _____

Did you quit smoking? _____ When (year)? _____

Do you (or did you) drink alcohol? _____ If yes: how much? _____ For how many years? _____

Did you quit drinking? _____ When (year)? _____

Are you single / married / divorced / widowed (circle one)

Do you have children? _____ Ages, male /female _____

Risk factors for HIV/Hepatitis? _____ If yes: please specify _____

What is your profession/employment? _____

Are you opposed to receive possible lifesaving transfusion of blood products? _____

Do you have a Living Will? Yes No (circle one)

HEALTH MAINTENANCE

Have you ever had a colonoscopy (circle one) **NO**

YES: Most recent date of exam _____

Men only: Have ever had a prostate exam (circle one) **NO**

YES: Most recent date of exam _____

Women only: Have you ever had a mammogram (circle one)

NO

YES: Most recent date of exam _____



HEMATOLOGY ONCOLOGY PHYSICIAN EXPERTS

Bringing hope to cancer patients
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NAME: _____

DATE: _____

Medical Problems (Either *now* or in the past):

	YES	NO		YES	NO
LUNG PROBLEMS			KIDNEY PROBLEMS		
Bronchitis	()	()	Stones	()	()
Emphysem	()	()	Infection	()	()
Pneumonia	()	()	URINARYPROBLEMS		
Asthma	()	()	Bladder infection	()	()
Hayfever	()	()	Prostate disease	()	()
Other					
HEART PROBLEMS	()	()	GLAUCOMA	()	()
Heart Murmur	()	()	BLINDNESS	()	()
Heart Attack	()	()	DEAFNESS	()	()
Heart Failure (CHF)	()	()	SPECIAL DIET	()	()
Heart Pain (Angina)	()	()			
Pace Maker	()	()	POSITIVE HIV	()	()
Irregular Heart Beat	()	()	AIDS	()	()
Other			TUBERCULOSIS	()	()
BLOOD PRESSURE			ANEMIA	()	()
High	()	()	BLEEDING	()	()
Low	()	()	SEIZURE DISORDER	()	()
DIABETES			CONCUSSION	()	()
Juvenile type	()	()	STROKE	()	()
Adult onset type	()	()	BLOOD CLOTS (THROMBOSIS)	()	()
ARTHRITIS			CLAUSTROPHOBIA	()	()
Osteoarthritis	()	()	THYROID DISEASE	()	()
Rheumatoid Arthritis	()	()	Specify:		
Osteoporosis	()	()	BLOOD TRANSFUSION	()	()
Gout	()	()			
Other					
BOWEL PROBLEMS			PAST SURGERIES	DATES	
Peptic Ulcer	()	()	_____	_____	
Gallbladder Disease	()	()	_____	_____	
Colitis	()	()	_____	_____	
Hepatitis	()	()	_____	_____	
Cirrhosis	()	()	_____	_____	
Other			_____	_____	

OTHER DISEASES (not surgical)

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answers your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children/ Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in patient's medical record.

12/06

Policy #:

Approved date: _____
Effective date: _____
President: _____
Clay Heighten, M.D.

Medical Release of Information Form

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I request and authorize _____
(Name of Physician and Clinic/Practice)

To release the medical information of the above named patient to:

Relationship: _____

Reason for release: _____

Name of recipient: _____

Address: _____

City & State: _____ Zip Code: _____

Phone: _____

This request and authorization applies to: (initial appropriate line)

____ Health Care information relating to the following treatment condition or dates of treatment:

____ All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

____ All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

____ I understand I have the right to revoke this authorization by providing a written request to do so.

Signature of patient or authorized representative

Date

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

This release expires 90 days after the date it is signed.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

1. What is the purpose of this notice?

The purpose of this notice is to advise you of the information and patient privacy policies of all of the medical practices that are a part of MedicalEdge Healthcare Group. In order to provide your healthcare and at the same time effectively manage our medical practices we must collect non-public personal information about you. We want you to know that we consider this information private and confidential, and that we have policies and procedures in place to protect this information against unlawful use and/or disclosure. This notice describes, to the best of our abilities, the types of information we collect and when, how and for what purposes it may be disclosed to others. If you have questions about this information or our policies and procedures please don't hesitate to call our Director of Compliance at MedicalEdge Healthcare Group at 972-739-3070.

2. What is "Non-public Personal Information"?

Non-public personal information ("NPI") is information specific to and may serve to identify an individual who is currently receiving or who has received medical care from one of the medical practices or providers of MedicalEdge Healthcare Group ("MEHG"). Among other things, this information may include details about the person's physical or mental health, the medical care evaluation, testing and treatment they may have received, and other information relating to payment for these various services. NPI does not include information that is publicly available or information that is available or reported in a summarized or aggregated fashion that does not identify individual patients.

3. How is Non-public Personal Information protected?

MEHG is required by law to restrict access to NPI to those healthcare providers, employees and vendors of business services to the medical practices who must have access to the information in order to provide you with the best possible medical care. MEHG maintains physical, electronic and procedural safeguards to protect NPI against unauthorized access and disclosure. MEHG has, in addition, established the position of Director of Compliance. This individual, along with other employees who are engaged as needed, has overall responsibility for developing, educating employees about, and overseeing the enforcement of policies and procedures to safeguard NPI against inappropriate access, use or disclosure, consistent with applicable laws.

4. What personal information might be disclosed to outside third parties, and for what purposes?

MEHG does not disclose NPI to anyone, except with patient authorization or as otherwise permitted by law. Disclosures permitted by law include the following:

- Whenever necessary for the patient's care and treatment or related activities, NPI is shared internally within the practices of MEHG.
- Whenever necessary for the patient's care and treatment or related activities, NPI is shared externally with other healthcare providers (doctors, physician's assistants, dentists, pharmacists, hospitals or other caregivers), insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits that a patient may receive under the terms of a healthcare plan), vendors, consultants, government authorities, and their respective agents. For example, NPI may be provided to your insurer as they attempt to determine the medical necessity of testing and treatment recommended to you by one of MEHG's physicians. All of these external parties are required in turn to keep your NPI confidential as provided by applicable law.

In addition to the uses described above, MEHG routinely utilizes NPI to provide patient appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

On your first visit to an MEHG healthcare provider you will be asked to sign an authorization for the permitted uses of NPI. MEHG will not use NPI for any purpose other than those falling within the scope of the above policy statement without the patient's written permission to do so. You have the right at any time to revoke this authorization in writing to your MEHG healthcare provider.

5. How may a patient request other disclosures of personal information?

Should you wish to have a copy of your own NPI you may request it by calling the Director of Compliance at the telephone number listed in Section 1. above. You must complete a written NPI Copy Request Form and MEHG will arrange a time for you to review your NPI and decided which pages, if any, you desire to have copied. MEHG will charge you \$1 per page to help to defray the costs of locating and duplicating this information. Applicable law provides that you have the right to notify us of any errors or inconsistencies in your NPI and that we maintain a record of your comments and amendments in this regard.

Should you wish us to disclose your NPI to other third parties or for reasons other than those addressed in Section 4. above, you must also complete a written NPI Copy Request Form and MEHG will decide, on an individual case basis, whether or not a charge for this service is applicable depending upon the proposed use of the NPI. In general, the provision of NPI for the purposes of on-going medical care or payment for services will be done at no charge, while that for all other purposes will involve a charge.

You also have the right under current law to request restrictions on certain uses and disclosures of your NPI permitted under applicable law, though current law does not require MEHG to necessarily agree to honor the requested restrictions.

6. What does MedicalEdge Healthcare Group do with personal information if and when you no longer obtain your medical care through one of our practices?

NPI is not destroyed when patients leave our care. The information continues to be available for use for all of the purposes described in Section 4. above, and in most cases is subject to legal retention requirements (typically, 7 years).

7. How is this notice being distributed?

This notice will be provided to all new MEHG patients at the time of their first visit. Current patients will receive a copy as they visit our offices in the course of their usual healthcare activities over the coming months.

MEHG reserves the right to change the terms of this notice and to substitute the provisions of the new notice in regards to all NPI we maintain. MEHG is required by law to make all reasonable effort possible to see that you receive a copy of the new notice if and when any policy changes are made.

8. What to do if you have reason to believe we may have violated our own patient information and privacy policies?

If you believe our Patient Information and Privacy Policies have been violated with respect to the NPI of yourself or your dependents, please contact our Director of Compliance at MedicalEdge Healthcare Group at 972-739-3070. We will be happy to provide a copy of our internal grievance procedures regarding these issues upon your request to do so.