ELITE PRIMARY CARE

REGISTRATION FORM Today's Date: _____

Patient's last name:	First:			Middle:
Marital status:	Birth date:		Age:	Race:
Ethnicity: ○ Not Hispanic * ○ Hispanic ○ Latin	Driver's License #:	Social Security #:	Sex: ○M ○F	Your Pharmacy/location:
Address:				
Home phone:	Cell phone:		Email:	
Occupation:	Employer:		Work phone:	

Chose clinic because/referred to clinic by:

Other family members seen here:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Person responsible for bill: *(self or parent)*	Birth date:	Address (if different):	Phone:
Is this person a patient here?	● Yes ● No	Occupation/Employer:	Work phone:

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? *circle one:*

Medical info only *Appointment info only* *Both*

Person's Name: Relationship to patient:

Person's Name: Relationship to patient:

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access.

* (this does not apply to controlled substances) ○ I elect to OPT-OUT

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Elite Primary Care to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Elite Primary Care for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. Charges for the collection of delinquent accounts, court costs, and or reasonable attorney's fees will be added to the total balance; including contingent fees to collection agencies of not less than 35%, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my provider, or any person employed by or under the direction and control of my provider, is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

_____ _____

Patient/Guardian signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

2690 Madison Street, Suite 130
Clarksville, TN 37043
Phone (931) 245-1701
Fax (931) 245-1720

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care 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.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

OFFICE POLICIES

Appointments

- **Scheduling:** You can schedule appointments by calling our office or submitting a request on our website along with the date and time that works best for you. However, online scheduling is only for Well checks. For urgent appointments we ask that you please call our office directly.
- **Late show:** If you are more than 5 minutes late for your scheduled appointment, your appointment may be rescheduled. Exceptions are made for emergencies.
- **Cancellations:** If you cannot make your appointments, please give us the courtesy of at least 24 hours notice so that another patient may have the opportunity to see the doctor. Arriving 10 minutes early will ensure that you and other patients are seen in a timely manner.
- **No Shows:** If you fail to show for an appointment, it is considered a NO SHOW. Our office does not tolerate NO SHOWS, and we have the right to terminate you from our office per our protocol. **Office protocol is to dismiss a patient after 3 NO-SHOWs.**

Patients in Waiting Room and Exam Rooms: Due to limited space, only the patient is allowed in the exam room. Children under the age of 18 must be accompanied by parent or legal guardian.

Smoking: Smoking is prohibited per **property management**. Anyone smoking on property will be fined **$100.00**

Payment: All payments / co-payments, outstanding balances are due BEFORE services will be rendered, unless prior arrangements have been made.

Requests for Prescription refills or forms: Requests for refills, forms for school, daycare or WIC can be submitted by the patient portal or telephone. Please allow 24-48 hours to complete. Calls on the weekend or holidays for prescription refills or appointments call will be returned on the next regular business day.

Messages for your Provider: Messages can be submitted using the patient portal or by calling our office directly. All telephone calls or messages of non-emergency will be answered by the end of the business day.

By signing these policy statements, I acknowledge that I have read all policies and practices of Elite Primary Care and agree to follow according to above polices.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize:

Provider: _____ Provider: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: __Elite Primary Care_____

Purpose of disclosure: ○Changing PCP ○Moving out of town ○Other: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed Relationship to Patient