PATIENT REGISTRATION FORM

Date: _______________ Preferred Pharmacy: ___________________________ Pharmacy Phone: _________________

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON BEING SEEN TODAY.

Patient's Name (First, Middle Initial, Last):

Date of Birth: ______________________ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Address: _____________________________________ City: _______________________State: _____ Zip: __________

Home Phone: ____________________ Cell Phone: _____________________ Work Phone: ____________________

Employer Name: ____ Employer Phone: _________________________

Race: ____ White/Caucasian _____ Black/African American _____ Asian ____ Decline______ Other(explain): _________

Ethnicity: ____ Non-Hispanic/Non- Latino ____Hispanic/Latino ____Unknown ____Decline

Preferred Language: ____ English ____Spanish ____ Other: _______________________

Patient's Emergency Contact: ____________________ Relationship: __________ Phone: _________________________

Patient's Preferred Contact Information:

Phone Number: ______________________ Email Address: ____

Patient's Employer: _______________________ Occupation: _________________ Phone: ________________________

Business Address: _____________________________________ City: _________________State: _____ Zip: __________

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR RELEASE OF MEDICAL INFORMATION.

□ I do not authorize any information to be released to anyone other than myself.

- Do we have your permission to leave you messages on a voicemail? Yes / No
- Do we have your permission to discuss your medical condition with any member of your household? Yes / No.

I hereby authorize my protected health information (ex: appointment information, results, medications) to be discussed with the following individuals. Name and Relationship:

1) Name: ____ Relationship: _________________________
2) Name: ____ Relationship: _________________________
3) Name: ____ Relationship: _________________________
4) Name: ____ Relationship: _________________________

PATIENT REGISTRATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON WHO IS RESPONSIBLE FOR THE PATIENT.

Responsible Person's Name (First, Middle Initial, Last): ____

Date of Birth: _____________________ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Address: ___________________________________ City: ______________________State: _____ Zip: __________

Home Phone: ___________________ Cell Phone: ____________________ Work Phone: _________________

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION FOR THE PATIENT.

Primary Insurance Carrier: ______________________ Subscriber's Name: _______________________________

Subscriber's ID: _________________________ Group#: _____________________

Date of Birth: ____________ Sex: ____ Social Security #: ___-___-_____ Relationship to Pt: ____________________

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY AND CURRENT SYMPTOMS

Briefly explain the reason for coming to the clinic today: (List symptoms, duration, severity, and location):

____

____

Please list below all current medications with dosage (include over the counter and herbal medications)

____

____

____

Please list any allergies you have and the reactions you experience:

____

____

Patient Signature: _______________________________________ Date: ___________________________

If patient is a minor, please have the legal guardian sign. Your signature acts as a consent to be treated.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties following the Notice: The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff, and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

- Treatment — As required by law
- Payment — Lawsuits and disputes
- Auditing — Public health purposes
- Research — Activities of our affiliates
- Organ Donation — Law enforcement purposes
- Fundraising — To military command authorities
- Health Care Operations — National security and protective services
- Appointment Reminders — Too avert a serious and protective services
- Workers' Compensation — Too coroners, medical examiners, and funeral directors
- Health oversight activities — Activities of managed care networks in which we participate

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories- Individuals involved in your care or payment.

Your Privacy Rights: You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health care.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of health information.

Change to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Hospital and Clinics.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Hospital Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT

Patient Acknowledgement: I acknowledge that I have received a copy of the Notice of Privacy Practices for Habersham Medical Center. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Time/Date: ___________________________ Signature of Patient: ____

For use by Hospital Personnel Only: (Complete if patient acknowledgement has not been obtained)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because: ___________________________

Time/Date: __________________________ Signature of Hospital Representative: ____

PATIENT PORTAL REGISTRATION

The patient portal is available through Habersham Medical Center's website. Through this portal the patient is able to view medication lists and discharge information, test results, message providers, as well as schedule appointments. If you are interested in signing up for the patient portal, please complete the form below.

Patient's Name (First, Middle Initial, Last):

____

Date of Birth: ____________________ Last four of Social Security: _____________

Email Address:

____

Please sign below authorizing temporary patient portal information to be sent to the above email address listed. ID must be presented at time of request. We cannot look up copies of ID that may be on file.

Signature: _______________________________________ Date: ________________________

Witness: ____ Date: ________________________