PHYSICIAN PARTNERS
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Full Name: _____ Patient prefers to be called: _____

Date of Birth: _____ Social Security #: _____- _____-_____ Sex: □Male □Female

Mailing Address:_____ Apt/Unit#:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____Cell Phone: (_____)_____

Marital Status: □ Single □ Married □Divorced □Widowed □Separated Email: _____

Referring Physician: _____ Primary Care Physician: _____

Patient's Employer Name: _____

Employment: □ Full-time □Part-time □Not working □ Self Emp □ Retired □ Military Student: □Full-time □Part-time □N/A

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone: (_____)_____ Emergency Contact Other Phone:(_____)_____

FOR CHILDREN - guarantor information/responsible for payment:

Guarantor Name: _____ Guarantor Relationship:_____

Guarantor Date of Birth: _____Guarantor Address: _____ Apt/Unit#: ____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION- <u>PRIMARY PLAN</u> -POLICY INFORMATION

Insurance Company:_____ Subscriber name: _____

Cert/Policy #: _____ Group Name: _____

Group#:_____ Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □Child □ Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: ____ Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

INSURANCE INFORMATION - <u>SECONDARY PLAN</u> - POLICY INFORMATION

Insurance Company:_____ Subscriber name: _____

Cert/Policy #: _____ Group Name: _____

Group#:_____ Policy Telephone #: _____

Relationship to the insured: □ Self □ Spouse □ Child □ Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: ____ Zip: _____

Policy Holder Date of Birth: _____ Policy Holder Sex: □Male □Female

EDUCATION: We want to provide education regarding your health conditions and would like to know the following:

My Preferred teaching method is: □ I have no preference □ Written education materials □ Demonstration

Barriers to learning: □ Language barrier □ Poor eyesight □ Poor Hearing □ Other _____
□ No barriers

Would you like someone with you during any education? (Name)_____(Relationship) _____

Primary Language: □English □Spanish □Other: _____

Race: □ Asian □ African American □American Indian □ Caucasian □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other: _____

Contact Preference: □ Phone □ Email □ Text _____

PHYSICIAN PARTNERS ASSIGNMENTS and AUTHORIZATIONS

CONSENT TO TREATMENT: I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of local anesthetics and/or blocks, and any and all medications and technical procedures which in the judgment of the Healthcare Provider attending and consulting may be considered necessary and advisable to treat while I am a patient of a provider in the employment of Physician Partners. I understand that an additional Informed Consent would be obtained from me after a full explanation before any type of Surgery or Invasive procedure would be done. In addition, I consent to the appropriate disposal by Physician Partners of any specimens or other bodily materials removed during technical procedures or for testing purposes. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made as to the results of any therapies and or procedure(s).

PATIENT'S VALUABLES: Physician Partners does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby certify that the information provided by me in order to apply for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to Tallahassee Memorial Healthcare and its Physician Partners of all benefits due me under the terms of said policies and programs. I assign payment to the provider(s) rendering medical services and the provider(s) for whom the organization is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance/copayments or any other charges incurred which are not paid by my insurance or other third-party payors together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RELEASE OF INFORMATION: I understand that my healthcare information will be exchanged among my health care providers through a Health Information Exchange (HIE). TMH will follow state and federal laws, including HIPAA, when protecting the release of sensitive information, which includes but is not limited to behavioral health, drug/alcohol/substance abuse, abuse treatment, sexual abuse, genetics testing, HIV/STD and adoption records. Participating in the HIE is not a condition to receive health care, and I may opt-out (decline) participating in the exchange. I also authorize Tallahassee Memorial Healthcare and its Physician Partners and any provider examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis, or persons or entities such as regulatory agencies or quality organizations.

CONSENT TO CONTACT: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from TMH and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services provided by Tallahassee Memorial Healthcare and its Physician Partners.

HMO ELIGIBILITY GUARANTEE: I hereby certify that if I am enrolled in an HMO and/or Medicaid HMO that I am receiving healthcare services through the Primary Care Physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a statement/bill from Tallahassee Memorial Healthcare and its Physician Partners.

PRIVACY NOTIFICATION: I have received notice of the Tallahassee Memorial Healthcare Notice of Privacy Practices and understand that I may obtain a copy of this notice upon request.

My signature below represents that I have read the above and thereby give my agreement and authorization to all of the above.

_____ _____

Printed Patient Name | Date of Birth

_____ _____ _____/_____

Patient Signature or Patient Representative | Relationship to Patient (if signing on their behalf) | Date/Time

TALLAHASSEE MEMORIAL HEALTHCARE

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION Date(s) of Service Requested: **___/___/___ to** **___/___/___**	NAME:_____ DATE OF BIRTH:____/_____/____ LAST 4 NUMBERS OF SSN:_____ DAY PHONE: _____ ADDRESS:_____ CITY: _____STATE:_____ZIP CODE:_____
RELEASING PARTY (***Who*** has the information you want released?)	NAME:_____ ADDRESS:_____DAY PHONE:_____ CITY:_____STATE:_____ZIP CODE:_____ FAX NUMBER: _____ (**URGENT CARE PATIENT ONLY)**
RECEIVING PARTY (***Where*** do you want the information sent? ***Who*** may have the information?)	NAME:_____ ADDRESS:_____DAY PHONE:_____ CITY:_____ STATE:_____ZIP CODE:_____ FAX NUMBER: _____**(URGENT CARE PATIENT ONLY)**

HOSPITAL (check all that apply):	**OFFICE/CLINIC (check all that apply):**	**BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply):**
□ Hospital Summary □ Discharge Summary □ History and Physical □ Consultation Reports □ Operative Reports □ Laboratory Reports □ Radiology Reports/ X-Ray Reports □ Pathology Reports □ Entire Record (not including psychotherapy notes)	□ Emergency Record □ Cardiac Reports/ EKG □ Other_____ _____ _____ _____	□ Office Visits □ Immunizations □ Physical Exam □ Laboratory Reports □ Radiology Reports □ Other_____ □ Entire Record (not including psychotherapy notes)	□ Hospital Summary □ Discharge Summary □ Assessments □ Progress Notes □ Laboratory Reports □ Medications □ Entire Record (not including psychotherapy notes)

FORMAT: □ USB/ CD □ Paper □ Other_____ **DELIVERY METHOD:** □ Mail □ Pick-up □ Fax, where permitted

PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at anytime. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above; **2)** Any cancellation will apply only to information not yet released by facility or practice; **3)** Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; **4)** Refusing to sign this form will not prevent my ability to get treatment; **5)** TMH will not share or use my health information without my permission other than by ways listed in TMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; **6)** A fee may be charged for providing the protected health information; **7)** I have a right to receive a copy of this form upon my request.

I DO NOT WANT TO RELEASE (check all that apply):
□ HIV/AIDS □ GENETIC INFORMATION □ SEXUALLY TRANSMITTED DISEASE (STD) □ DRUG/ALCOHOL □ MENTAL HEALTH

This permission expires one year after the date of my signature unless another date or event is written here:_____

Signature: _____ Print Name:_____ Date:_____

Witness Signature: _____ Print Name:_____ Date:_____

Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral/ mental health without parental consent, the minor must sign this authorization.

Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form.
Check the box below to indicate the relationship/ authority (Written Proof May be Requested):
□ Healthcare Agent/ POA □ Guardian □ Executor/Administrator/Attorney in Fact □ Spouse
□ Parent □ Adult Child □ Affidavit Next of Kin □ Other_____

PHYSICIAN PARTNERS
Verbal Communication Authorization

I, _____ DOB_____, authorize Tallahassee Memorial Physician Partners to **verbally disclose protected health information contained in my medical and billing records** to the individual(s) indicated below. I understand that the purpose of this disclosure is to facilitate communication regarding my medical care. I further understand that this does not authorize release of medical record copies, which requires a separate written authorization by me.

_____I specifically authorize the release of any and all medical information, including that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

_____ _____
Initials ***Date/Time***

Special Instructions or Restrictions on Disclosure: Contact number: _____
May we leave a voicemail at this number? : [ ] Yes [ ] No
May we leave a text message at this number? [ ] Yes [ ] No
Other: _____

The information indicated above may be released to:

Name:_____ Relationship:_____

Phone number:_____

I understand that I have the right to revoke this authorization, except to the extent that Tallahassee Memorial Physician Partners-_____ has already taken action based on it. I also understand that when my health information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of the information identified on this authorization is voluntary and I need not sign this form to ensure health care treatment.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient (*attach documentation of guardianship or Power of Attorney if applicable*) Date/Time witnessed

_____
Date signed

****

REVOCATION OF AUTHORIZATION: I hereby revoke the previous authorization allowing disclosure of my protected health information to the above-named individual.

_____ _____
Signature of Patient or Patient's Representative Date/Time

TALLAHASSEE MEMORIAL HEALTHCARE
Ambulatory Care Services

To Our Patients:

Under the Patient Self-Determination Act it is your right under law to accept or refuse medical care. Advance Directives can protect this right if you ever become mentally or physically unable to choose or communicate your wishes due to an accident or an illness.

An Advance Directive is any instruction you give relating to the provision of healthcare in the event you become unable to make your own decisions. Examples of Advance Directives include: Living Will; Durable Power of Attorney; Appointment of a Healthcare Surrogate. When using Advance Directives, you protect your right to make medical choices that can affect your life; your family can avoid the responsibility and stress of making difficult decisions; and your physicians will have guidelines for providing your care.

Living Wills are written instructions that explain your wishes regarding healthcare should you have a terminal condition such as cancer, Alzheimer's disease, etc. They are called Living Wills because they take effect while the patient is still alive.

A Durable Power of Attorney for Healthcare allows you to name a person (called a surrogate/proxy) to make decisions for you if you become unable to do so. Also, in the Power of Attorney, you may list the healthcare decision that you desire concerning life-prolonging care, treatment, services and procedures, as well as special provisions and limitations. These life-prolonging measures may include cardiopulmonary resuscitation, intravenous therapy, feeding tubes, respirators, dialysis, pain relief, Do Not Resuscitate orders, and organ donation.

A Healthcare Surrogate (proxy) is a person you choose to make healthcare decisions for you if you are not able to do so for yourself. This person should be someone who knows your wishes and who will make decisions on what he/she believes you would want.

Once you have completed your Advance Directive, please discuss the details of the directive with your physician, family members, minister, surrogate and/or close friends. Make sure your surrogate has a copy of your Advance Directives, place a copy in the glove compartment of your car and give copies to those whom you feel should know.

If an emergency takes place in our office your Advance Directive would not immediately be honored because it is not possible in an emergency situation to determine your chance of survival or recovery. We would call 911 and begin our emergency procedures unless a physician is present who knows your medical history and Advanced Directive, and gives the order to stop. Otherwise, once you have reached the ER or hospital where a better determination of your condition can be made, your Advance Directive will be honored if you are not able to express your wishes.

If you need help in preparing Advance Directives or if you would like more information you may contact a lawyer, your State Attorney General's office, Hospitals, Hospices and Long-Term Care Facilities. You may also seek information and assistance from the Risk Management Department at Tallahassee Memorial HealthCare by calling (850) 431-5364.