PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name: (Last)_____ (First)_____(MI)_____

Preferred Name: (If different from above)_____ Date of Birth:_____

Address: _____ City, State, Zip: _____

Cell Phone Number: _____ Home: _____ Work:_____

Can we leave a detailed voicemail? ❑ Yes ❑ No Patient's SSN:_____

Email Address: _____

MaritalStatus: ❑ Single ❑Married ❑ Partner ❑ Other	Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Black/African American ❑ White ❑ Hispanic ❑ Choose not to disclose ❑ Other not listed: _____	Language Preference: ❑ English ❑ Spanish ❑Other_____
Gender: ❑ Female ❑ Male	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Choose not to disclose	Advance Directive/Living Will: ❑ Yes ❑ No You may provide us a copy at your discretion.

Patient HIPAA Acknowledgment

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME	RELATION	CONTACT NUMBER

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last)_____ (First) _____ Phone Number: _____ Do you have a living will? ❑ Yes ❑ No

Relationship to Patient: _____

PHARMACY INFORMATION

Name:_____Address:_____City, State_____

Signature:

I verify this information is True and Correct, _____Date: _____

HOMETOWN HEALTHCARE

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name	ID Number	Group Number
Claims Mailing Address	Claims City, State and Zip Code	Insurance Phone Number
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's SSN
Policy Holder's Address (if different than patient's)	Relation to Patient	❑ Female ❑ Male

SECONDARY INSURANCE

Insurance Name	ID Number	Group Number
Claims Mailing Address	Claims City, State and Zip Code	Insurance Phone Number
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's SSN
Policy Holder's Address (if different than patient's)	Relation to Patient	❑ Female ❑ Male

RESPONSIBLE PARTY INFORMATION (If not self)

Responsible Party: ❑ Another Patient ❑ Guarantor ❑ Self

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Gender: ❑ Female ❑ Male

Responsible Party Social Security Number: _____ Phone #: _____

Address: _____

City, State, Zip: _____

HOMETOWN HEALTHCARE

Medication, Allergies and Immunizations

Patient Name:_____ Date of Birth:_____

Current Medication/Supplement	Dose	Frequency (how often)

Allergies to Medications

IMMUNIZATIONS

Are you up to date: ❑ YES ❑ NO	Tetanus within last 10 years: ❑ YES ❑ NO

Menstrual History

Age of onset:	Date of Last Period:	Number of Pregnancies:
Painful Periods:	Irregular Periods:	Number of Miscarriages:

HOMETOWN HEALTHCARE

Medical History

Patient Name:_____ Date of Birth:_____

Surgical History: Procedure, Reason and Date

PAST MEDICAL HISTORY (Check if you or family member have or had the following)

Indicate which family member has or had one of the following:
***(F)** Father **(M)** Mother **(S)** Sister **(B)** Brother **(GM)** Grandmother **(GF)** Grandfather*

☐ Asthma	☐ Ulcers	☐ Heart Failure	☐ Osteoporosis
☐ Angina	☐ Thyroid	☐ Endometriosis	☐ High Blood Pressure
☐ Gout	☐ Valley Fever	☐ Tuberculosis	☐ Degenerative Arthritis
☐ Stroke	☐ Migraines	☐ Kidney Stones	☐ Rheumatoid Arthritis
☐ COPD	☐ HIV/ARC/AIDS	☐ Venereal Disease	☐ Emphysema
☐ Bleeding Tendency	☐ High Cholesterol	☐ Erectile Dysfunction	☐ Heart Attack

☐ Diabetes Type_____ Age_____ ☐ Cancer Type_____ ☐ Heart Attack Age_____ ☐ Other _____

Mother's Age:_____If Deceased, age and cause of death:_____
Father's Age:_____If Deceased, age and cause of death:_____

SOCIAL HISTORY

Type of Work:_____ Stressful:_____Hazardous:_____Heavy Lifting:_____

Exercise: ❑ YES ❑ NO # ____ days a week

Alcohol: ❑ YES ❑ NO # ____ drinks per day *If you used to, when did you quit? _____

Do you smoke: ❑ YES ❑ NO # ____ daily *If you used to, when did you quit? _____

CONSENT TO TREATMENT

Thank you for choosing HOMETOWN HEALTHCARE as your healthcare provider. We are committed to providing quality medical care. We ask that you read, sign, and return this form to us prior to your treatment.

OFFICE STAFF TREATMENT

Hometown Healthcare's office staff makes every effort to answer and solve patient inquiries and to schedule patients as timely as they are able. Demeaning or disrespectful remarks or attitudes towards Hometown Healthcare staff will not be tolerated. If such behavior is encountered, you will be dismissed from the practice.

_____**I Acknowledge that I will be dismissed from the practice if I disrespect or demean the office staff at Hometown Healthcare.**

CONSENT FOR MEDICAL TREATMENT

Patient, or patient's legal representative, agrees to the following terms of treatment:
I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury or health concern affecting me at any time I am present at HOMETOWN HEALTHCARE. These services may include, but not limit to, laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures. I have read and understand this treatment agreement. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and authorized to act on behalf of the patient to sign this agreement.

FINANCIAL POLICY

• All patients must provide accurate and complete personal information prior to being seen by the doctor.
• Payment is required at the time of service and may be in the form of cash, check, debit, or credit card.
• HOMETOWN HEALTHCARE may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.
• We will gladly file your claim with your insurance. It is your responsibility to comply with any predetermination or notification requirements of your insurance plan. Many of the services provided may be covered and paid for by your insurance company. Unfortunately, insurance companies do not pay for all services that the provider may deem appropriate.
• In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.
• The Guarantor agrees to pay any and all applicable fees should the account be referred to an outside collection agency, including, and not limited to 33% of the account balance at the time it is sent to collections.
• HOMETOWN HEALTHCARE may charge reasonable fees for services related to your account including, but not limited to, interest on unpaid accounts, and medical record copies.
• Your personal information will be verified/updated at each visit, to ensure information on file is accurate.
• We will collect a deposit on the charges you incur today toward your balance (e.g. copay, deductible, coinsurance, self pay) and bill you for any remaining balance.
• Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We are not allowed to change information just so the insurance company can pay a claim.

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to HOMETOWN HEALTHCARE and authorize them to submit a claim on my behalf. I understand that I am financially responsible for any non-covered service. I authorize HOMETOWN HEALTHCARE to release any information required to process claims for my care and treatment. I have read and understand the financial policy and agree to abide by it.

I have read the above statements and consent to treatment:

Signature of Patient or personal representative:_____ Date:_____
Print name:_____

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information"(PHI) by HOMETOWN HEALTHCARE in order to carry out treatment, payment, or health care operations. The patient should review Premier Health's Notice of Privacy Practices for Protected Health information for a more complete description of the potential uses and disclosures of such information and the patient has the right to review such Notice prior to signing this consent form.

HOMETOWN HEALTHCARE reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If HOMETOWN HEALTHCARE does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice requesting a copy.

I understand that, and consent to, the following appointment reminders that will be used by HOMETOWN HEALTHCARE, by email, a telephone call at designated number and leaving a message on a voice mail or with a person answering the phone.

This consent is valid for seven years. At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the facility in writing. The revocation shall be effective except to the extent that HOMETOWN HEALTHCARE has already taken action in reliance on the Consent.

HEALTH CURRENT

I acknowledge that I received and read the notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the (HIE) unless I complete and return an OPT out form to my healthcare provider.

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Signature of Patient or personal representative:_____ Date:_____

Print name:_____

Authorization for Disclosure of Protected Health Information

Patient Name:_____Date of Birth:_____

Information to be released by:	Information to be released to:
	Hometown Healthcare
Name of Organization / Person	Name of Organization / Person
	3001 N. Main Street, Suite 1B
Street Address	Street Address
	Prescott Valley, AZ 86314
City, State and Zip Code	City, State and Zip Code
	(928) 259-5506
Phone Number	Phone Number
	(888) 494-0749
Fax Number	Fax Number

This information is to be disclosed to HOMETOWN HEALTHCARE for the purpose of medical care. I understand this authorization may be revoked in writing at any time, except to extend that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from today. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I am aware that this
information may be sent via fax and or carrier agency (i.e. US Mail, Federal Express, UPS, etc.).
I understand the medical records may include information relating to:

- Acquired immunodeficiency Syndrome (AIDS) or infection with Human immunodeficiency virus (HIV)
- Psychiatric Care
- Treatment for Alcohol and/ or Drugs Abuse
- Communicable Disease

Signed:_____Date:_____
(Patient/Parent/Guardian)