PEACHPOINT CLINIC
Better Care. Better Health.

Patient Registration Form

PERSONAL INFORMATION

FIRST NAME_____ MI _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE_____ HOME PHONE_____ EMAIL _____

DATE OF BIRTH _____/_____/_____ SEX: FEMALE ☐ MALE ☐

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER

RACE ☐ BLACK ☐ WHITE ☐ ASIAN ☐ HISPANIC ☐ WHITE NON-HISPANIC ☐ OTHER

COMMUNICATION PREFERENCE ☐ MAIL ☐ PHONE ☐EMAIL ☐PATIENT PORTAL

How did you hear about us? _____ Referral Source: _____

EMPLOYER INFORMATION

PATIENTS EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS_____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

WORK PHONE_____ CELL PHONE _____ HOME PHONE _____

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GUARANTOR'NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/_____ SEX _____ WORK/HOME PHONE _____ CELL PHONE_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

INSURANCE INFORMATION

INSURANCE _____ INSURED'S NAME _____

ID# _____INSURED'S BIRTHDATE ___/___/_____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE _____ INSURED'S NAME _____

ID# _____INSURED'S BIRTHDATE ___/___/_____ RELATIONSHIP TO PATIENT_____

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HIPAA Authorization & Patient Consent Form

1. Authorization

I _____(First Name, MI, Last Name) hereby authorize **Peachpoint Clinic** to use and disclose the protected health information below to the following individuals

Name (Print)	Relationship to Patient
Name (Print)	Relationship to Patient

I, _____ received a copy of Peachpoint Clinic Notice of Privacy Practices.

I _____ give permission for Peachpoint Clinic to leave any medical, lab and appointment reminder information for me at the following telephone numbers.

Cell Phone No.	
Home No	
Work No.	

2. Extent of Authorization

I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Name (Please print):_____ Patient DOB:_____/____/_____

Patient Signature:_____ Date: _____/____/_____

Responsible Party Name(If not patient)_____

Responsible Party Signature:_____Date: _____/____/_____

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Privacy Practices Acknowledgement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We have posted a detailed policy on our website at www. Peachpointclinic.com. Please review it carefully. By signing this agreement, you acknowledge that you have received a copy of our notice of privacy practices and you consent to our use of your information

Our Responsibility:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Your Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Uses and Disclosures

- **Treatment**. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
- **Payment**. Your health information may be used to seek payment from your health plan, from other sources of coverage.
- **Health care operations**. Your health information may be used as necessary to support the day-to-day activities and management of our office.
- **Law enforcement**. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
- **Public health reporting**. Your health information may be disclosed to public health agencies as required by law.
- **Appointment reminders**. Your health information will be used by our staff to send you appointment reminders.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Legal Representative Signature: _____ Date: _____

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Patient Financial Policy Agreement

Proof of insurance/Self Pay. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and proof of current health insurance at every visit. If you fail to provide us with the proof of current health insurance or if you are uninsured, you will be considered a self-pay patient and will have to pay the self-pay fees.

Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments, Co-Insurance and Deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. It is your responsibility to pay for all co-insurances and deductibles as contracted with your insurance company.

Non-Covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your health insurance company. You are responsible for paying any portion of the charges your policy does not cover.

Claims Submission. As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. We do not file claims to tertiary plans, only to your primary and secondary insurance policies. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-Payment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed Appointments/No Show Our policy is to charge for missed appointments. If you do not show up for an appointment or cancel at least **24 hours prior**, there will be a missed appointment fee of **$30.00**. Please help us to serve you better by keeping your regularly scheduled appointment.

Prescription Refill Policy _____Initial
Please allow **48 – 72** hours for all prescription refills. To speed up the process, please ask your pharmacy to send a refill request to the clinic.

Medical Records Policy _____Initial
We are happy to provide you with a copy of your medical records. A cost may be associated depending on the number of pages requested.

Effective Date: By signing this agreement, you agree to all the terms and conditions contained herein.

Patient Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

Parent/Legal Representative Signature: _____ Date: _____