PATIENT REGISTRATION FORM

PM PATIENT NUMBER

Social Security #: Date of Birth: Patient Name: Address: Home Phone #: Cell Phone #: Email Address: Sex: Is patient a full time student? Y N Marital Status:	Today's Date: *Ethnicity: *Race: *Language Preference: *Note: Information being requested by the government for reporting purposes.
EMPLOYER INFORMATION	**EMERGENCY CONTACT**
Employer: Occupation:________________ Employer's Address: Work Phone #:______________	Name: Address: Home Phone #: Work Phone #: Relationship to patient: DOB
GUARANTOR INFORMATION	**PRIMARY INSURANCE INFORMATION**
Please complete for the person responsible for the bills (if other than patient). Required for patients under age 18. Guarantor Last Name: First Name: Guarantor SS #: Guarantor DOB: Guarantor Address: Guarantor Relationship to Patient:	Insurance Company Name: Address: Name of Subscriber: Subscriber DOB: Subscriber SS#: Co-pay (if applicable): Relationship to Patient: Policy Number: Group#: Effective Date of Policy:
PHARMACY INFORMATION	**SECONDARY INSURANCE INFORMATION**
Local Pharmacy Name: Address: Phone#: Fax#: Mail-In Pharmacy Name: Address: City, State, Zip: Phone#: Fax#:	**IMPORTANT! Do you have any other medical insurance?** Insurance Company Name: Address: Name of Subscriber: Subscriber DOB: Subscriber SS#: Co-pay (if applicable): Relationship to Patient: Policy Number: Group#: Effective Date of Policy:

OTHER:

How were you referred to our practice?

Physician Referral Name of Primary Doctor: Phone Number:

Address:

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I (or designated guardian) authorize the Physician to provide treatment and to release medical information to my insurance as may be necessary for payment of physician claims.

I (or designated guardian) hereby authorize payment directly to the Physician of the benefits otherwise payable to me but not exceed regular charges for physician claims. I (or designated guardian) understand that I am financially responsible to t Physician for charges not covered by my insurance.

X______________________________ ______________________

PATIENT AND/OR GUARDIAN SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize my Physician to supply to another physician involved in my medical care a copy of necessary medical records and/or test results requested' by the Physician but ordered by my Primary Care Physician. I understand this is for the release of medical information only. If I am a managed care subscriber, I authorize my Physician to allow my Managed Care Organization access to my chart for Quality Review purposes.

X______________________________ ______________________

PATIENT AND/OR GUARDIAN SIGNATURE DATE

MEDICARE PATIENTS

MEDICARE BENEFITS (Please Sign) Patient's certification, authorization to release information and payment request certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my beha for authorized benefits under my health insurance. I hereby authorize payment directly to my Physician for insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for these claims. I understand that I am financially responsible to my Physician for charges not covered by this authorization. I understand that my Physician will bill HCFA using the term "signature on file" and am aware that my signature as written below constitutes that "on file signature.

X______________________________ ______________________

PATIENT AND/OR GUARDIAN SIGNATURE DATE

MEDIGAP BENEFIT'S (Please Sign) I hereby give my Physician permission to ask for Medigap payments for my medical care. understand that my Medigap Insurer nee.ds information about me and my medical condition to make a decision about these payments.I give permission for that information to go to my Medigap Insurer.

I request that payment of authorized Medigap benefits be made to FHCS Physician Services on my behalf for any services furnished me by my Physician. I authorize any holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits or the benefits payable for related services.

X______________________________ ______________________

PATIENT AND/OR GUARDIAN SIGNATURE DATE

CONSENT OF TREATMENT FOR MINOR /INCAPACITATED PATIENTS

I hereby authorize the Physician to provide medical treatment to______________________________

Patient is unable to consent to medical treatment because minor child / other

____

____

____

X____________________/___ X______________________ X______________________

SIGNATURE OF GUARDIAN/ DATE NAME OF GUARDIAN WITNESS SIGNATURE

Aria Health Physician Services Patient Responsibility Policy

We at Aria Health Physician Services are pleased you have given us the opportunity to serve your medical needs. We firmly believe that a good physician- patient relationship is based upon understanding and communication and we want you to be aware of our financial policy. A copy will be provided to you upon request

Insurance. We participate in most insurance plans. If you are not insured by a plan we participate in or are self-pay, payment in full is expected at each visit. We will ask you to present your current valid insurance card at each visit.

Co-payments. Co-payments are expected to be paid at the time of your visit.

Claims submission. We will submit your claims to your insurance and assist you in any way we reasonably can to help get your claims paid. We have agreements with many insurance companies and accept as payment the amount specified in the agreement. You will be responsible for all amounts not paid by your insurance, including amounts applied to deductible or considered non-covered.

Non-covered services. Your health insurance is a contract between you and your insurance company. Please be aware that not all services are covered in all insurance policies. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. In the event your insurance plan determines a service to be not covered, you will be responsible for the complete charge.

Insurance coverage changes. If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits.

Accepted forms of payment. We accept cash, check and credit cards.

Completion of forms. There is a processing fee for the completion of forms, which were not part of an office visit. Examples are disability forms.

Missed appointments. Our office requires advance notice if you are unable to keep your appointment. Failure to do so may result in an administrative charge. We request, at least, 24 hours' notice (one business day) if you will not be able to keep your appointment. Barring any unusual circumstances, if you fail to show up for more than 3 appointments within 6 months without canceling ahead of time, you may be dismissed from the practice.

Our practice is committed to providing the best treatment to our patients. Our fee schedule is representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the patient responsibility policy and agree to abide by its guidelines:

____ ____________________

Signature of patient or responsible party Date

____

Printed name of patient

Acknowledgment of Receipt of

Notice of Privacy Practices

PATIENT NAME: DATE OF BIRTH:

This Notice describes how your medical information, also referred to as Protected Health Information (PHI) may be used and disclosed and how you can get access to this information

Please review carefully.

By signing below, I hereby acknowledge receipt of Aria's Notice of Privacy Practices.

PATIENT NAME DATE

If you would like to give us permission to disclose your health information to someone else on your behalf, please provide the name and relationship to each person in the space provided below:

NAME	RELATIONSHIP
1.	
2.	
3.	
4.	

FollowMyHealth Patient Portal Registration

Individual age 18 and over:
Please fill in the patient information below and present a photo ID to your Aria Physician Practice staff.
Minor Proxy Account for under the age of 13:
Please fill in all sections below and present a photo ID to the patient's Aria Physician Practice staff. Parent or guardian is granted full access to view and manage a child's health information.
Dependent Adult Proxy Account for age 18 and over:
Please fill in all sections below and present a photo ID to the patient's Aria Physician Practice staff

Patient First Name

Patient Last Name

Patient Date of Birth

Patient Preferred Phone

Patient Email Address (N/A if proxy request)

Minor or Dependent Adult Proxy Account

Proxy Last Name

Proxy First Name

Proxy Birth Year

Proxy Preferred Phone

Proxy Address______________________________

Legal Relationship to Patient______________________________

Proxy Email Address

For Office Use Only

For Individual age 18 and over - Photo ID verified
For Minor Proxy Account - Photo ID verified
For Dependent Adult Proxy Account – Photo ID Verified Legal Documentation Scanned
Aria Staff Name (Please Print)______________________________ Date______________