Patient Registration / HIPAA and other consents

All shaded areas MUST be completed

Patient Name Last: ___________________ First: ___________________ Middle: ___________________ Maiden: ________________

Date of Birth: _______________ Age: _______ Sex: Male / Female Social Security #: _______-_____-_______ Marital Status: ___________

Physical Address: ____ City/State/ZIP: _____________________________________

Mailing Address: ____ City/State/ZIP: _____________________________________

Phone Home: (______) ________-_________ Cell: (______) ________-_________ Work: (______) ________-________ ext: _____________

Employer: ____________________ City/State/ZIP: _____________________ Email: ____

Consents & Contacts please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. **NOTE: If the patient is a minor, parent(s) must be listed**

►Name: ____ Relationship to Patient: ______________________________

Home Phone: (______) ________-_________ Cell Phone: (______) ________-_________ Work Phone: (______) ________-_______ ext: _____

►Name: ____ Relationship to Patient: ______________________________

Home Phone: (______) ________-_________ Cell Phone: (______) ________-_________ Work Phone: (______) ________-________ext: _____

►Name: ____ Relationship to Patient: ______________________________

Home Phone: (______) ________-_________ Cell Phone: (______) ________-_________ Work Phone: (______) ________-________ext: _____

If you would like TotalCare to file with your Insurance these fields MUST be completed.

Primary Insurance Company: ___________________ Policyholder: Last: ___________________ First: __________________ MI: ___

Policy ID number: ___________________________________ Group number: ___________________________________

(Policyholder Info) Relationship to Patient: ____________________ Social Security #: _______-_____-_______ Date of Birth: ______________

Address: ____ City/State/ZIP: ______________________________________

Home Phone: (______) _____- __________ Cell Phone: (______) ______ - _______

Secondary Insurance Company: _________________ Policyholder: Last: __________________ First: __________________ MI: ___

(Policyholder Info) Relationship to Patient: ____________________ Social Security #: _______-_____-_______ Date of Birth: ______________

Address: ____ City/State/ZIP: _____________________________________

Home Phone: (______) _____- ______ Cell Phone: (______) ______ - _______

By signing below I certify the above information to be true and correct.

Notice of Privacy Practice Acknowledgement: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Insurance (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that TotalCare has the right to change its Notice of Privacy Practices from time to time and that I may contact TotalCare at anytime at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that TotalCare restrict how my PHI is used or disclosed to carry out treatment, payment and health care operations.

I am aware that for my safety and protection, video and audio surveillance may be used on TotalCare premises, in public areas only.

I, the undersigned, as patient or on behalf of patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained. I understand that I have the right to revoke this consent, in writing, except where Total Care has already made disclosures in reliance on my prior consent. A photocopy of this signature is as valid as the original.

Patient or Parent/Guardian **Signature:** ____ **Date:** _______________________________

Print Patient or Parent/Guardian Name: ____ Parent/Guardian **DOB**: ________________

Guardian/Power of Attorney: Please see the front desk for additional documentation (required by law) to be completed.

Voicemail Consent

For your convenience, TotalCare will call to remind you about your upcoming appointments. Please give your consent below to allow us to leave you detailed messages.

Patient's Name: ____

Date of Birth: ____

☐ *TotalCare may leave detailed information regarding my appointment on the following phones.*
☐ *home voicemail* ☐*mobile phone voicemail* ☐ *work voicemail.*

☐ *I do not wish TotalCare to leave details on my voicemail.*

Family Statements

In order to streamline our services and for your convenience, TotalCare will be implementing family billing statements. You will now have your entire family's account in one, easy-to-understand format.

Head of Household Name: ___________________________ Date of Birth: ___________________

Mailing Address: _____________________________ City, State, Zip: ______________________

Please list anyone else in the family that should be included at the above address:

- Name: ______________________________________ Date of Birth: ___________________
- Name: ______________________________________ Date of Birth: ___________________
- Name: ______________________________________ Date of Birth: ___________________
- Name: ______________________________________ Date of Birth: ___________________
- Name: ______________________________________ Date of Birth: ___________________

* You must be on patient's HIPAA consent form to receive emails regarding their health and/or account with us.

X_________________________________
Patient's (Signed) Name
(Guardian signature if patient is under age 18)

X_________________________________
Date of Signature

X_________________________________
Patient's (Printed) Name

TotalCare
Employee Initials: ___________