REGISTRATION FORM

PATIENT INFORMATION

Patient/Child First Name: MI: Last Name:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female
Ethnicity? ☐ Hispanic ☐ Not Hispanic ☐ Refused Marital Status? ☐ Single ☐ Married ☐ Widowed/Divorced	Language Spoken? ☐English ☐ Spanish ☐Other Race? ☐ White ☐ Asian ☐ Black ☐Hispanic ☐ Indian/Native ☐Other		
Mailing address:		Social Security #:	
City:	State:	Zip Code:	Home Phone: Cell Phone: Work Phone:
Email Address: ☐I do not have access to email		Occupation:	
Is the patient covered by insurance? ☐ Yes ☐ No Current Pharmacy:_____Location**:**			

INSURANCE INFORMATION(*Please fill out ONLY if patient is on spouse or parent's insurance plan)

(Please give insurance card to the receptionist to be scanned. We are NOT responsible for filing claims if no card is on file)

PRIMARY INSURANCE ☐Medicare ☐ NC Medicaid ☐ BCBS ☐Other			Policy #:
Name on the insurance card? :	SS # of the policy holder(required):	Birth date of Policy Holder(required):	Group #:
How is the **patient** related to the policy holder? : ☐ Self(or Medicaid) ☐ Child (covered under parent's insurance) ☐Spouse ☐ Other			
SECONDARY INSURANCE ☐None	Policy Holder: ☐Same as primary	Date of Birth	Policy #:
Patient's relationship to subscriber: ☐Self(Medicaid) ☐ Child(covered under parent's insurance) ☐ Spouse ☐ Other			

PARENT/GAURADIAN (REQUIRED IF PATIENT IS UNDER 21 YEARS) NOTE: By Law, Both Parents can be held responsible for medical bills for minors, a medical practice is **NOT** bound by any separation agreement, divorce or child support order.

Parent/Guardian:	**Birth Date:**	Address (if different): ☐ Same as above
Social Security #(required):	Employer:	Preferred Phone #:

IN CASE OF EMERGENCY WHO WOULD YOU LIKE TO BE CONTACTED?

Contact Name:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

By signing, you agree the information above is correct and give permission for East Asheville Family Health Care to file claims on your behalf.
HIPAA CONSENT: *Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below.* ☐ *I do not wish anyone to have information regarding my care.*

1. _____

2. _____

X_____ ***Date:***_____
Patient/Guardian Signature

Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to East Asheville Family Health Care.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment if necessary. Please allow 24 hrs for a response to refill requests. Samples are given at scheduled appointments ONLY and can ONLY be given by the doctor.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

Patient/Guardian Signature for Financial and Office Policies
(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

X_____ Date_____

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies. *You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account. We may also contact you by email using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable.*

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager .

Signature (HIPAA Policy)

X_____Date_____