



INSTRUCTIONS

Page 1 - *Patient Registration Form* - fill out entire page and sign at bottom of page.

Page 2 - Complete *Records Release Form* as required for your upcoming office visit.

Page 3 – Complete the *Health History Questionnaire* (per specialty).

Bring all paperwork, filled out, to your scheduled appointment along with:

- Medical insurance and prescription cards
- Any recent labs or radiology workups
- Picture ID
- List of medications

If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.

NO SHOW POLICY

A FEE MAY BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR OFFICE VISIT WITHIN 24 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

Premier Medical Group of the Hudson Valley, P.C.

Urology · Gastroenterology · Internal Medicine · Cardiology · Rheumatology · Dermatology · Pediatrics · Podiatry

Poughkeepsie | Fishkill | Kingston | Rhinebeck | Newburgh | New Windsor | Montgomery | Washingtonville

Web: www.premiermedicalhv.com

PATIENT REGISTRATION FORM

PATIENT ACCOUNT NUMBER: _____

PATIENT INFORMATION

| | | |
|---|---|--|
| PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | PRIMARY PHYSICIAN |
| PATIENT'S ADDRESS | | EMERGENCY CONTACT AND TELEPHONE # |
| CITY | STATE | ZIP |
| STUDENT STATUS: If 18 years or older: (Circle one) Full Time Part Time Not a Student | | |
| TELEPHONE () | CELL PHONE () | DATE OF BIRTH / / MO DAY YEAR |
| MARITAL STATUS: (Circle one) Single Married Separated Divorced Widowed | | |
| RACE: | ETHNICITY: | PRIMARY LANGUAGE: |
| | | EMAIL ADDRESS: |

INSURANCE INFORMATION

| | |
|--|---|
| PRIMARY INSURANCE COMPANY NAME COPAY _____ | SECONDARY INSURANCE COPAY _____ |
| INSURANCE ADDRESS | INSURANCE ADDRESS |
| CITY | STATE ZIP |
| INSURED'S ID NUMBER GROUP PLAN NUMBER | INSURED'S ID NUMBER GROUP PLAN NUMBER |
| PATIENT'S EMPLOYER NAME TELEPHONE () | PHARMACY NAME TELEPHONE () |
| EMPLOYER'S ADDRESS | PHARMACY ADDRESS |
| CITY | STATE ZIP |

RESPONSIBLE PARTY INFORMATION

| | | |
|--|---|---|
| RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE) | SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | LEGAL REPRESENTATIVE <input type="checkbox"/> YES <input type="checkbox"/> NO |
| RESPONSIBLE PARTY'S ADDRESS | EMPLOYER'S NAME | |
| CITY | EMPLOYER'S ADDRESS | |
| TELEPHONE () | RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____ | |

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for Services rendered.

COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to an attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE. YOU SHOULD READ THESE TERMS CAREFULLY. THANK YOU FOR YOUR COOPERATION.

X _____ DATE _____

SIGNED (Patient, or parent if under 18 years of age)



AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: _____

I hereby authorize _____ to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____ FAX: _____

The following information is to be disclosed: (please check off those that apply)

Physician notes _____ Dates _____

Lab results _____ Dates _____

X-Ray reports _____ Dates _____

Operative reports _____ Dates _____

COMPLETE RECORD _____

Other: _____

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative

Date

Revised 4/29/15