PREMIER *medical group*

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
243 North Road
Poughkeepsie, NY 12601
(845) 471-9410

PATIENT ACCOUNT NUMBER

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SEX ❑ MALE ❑ FEMALE			PRIMARY PHYSICIAN
PATIENT'S ADDRESS			EMERGENCY CONTACT NAME 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	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	CITY STATE ZIP

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX ❑ MALE ❑ FEMALE	LEGAL REPRESENTATIVE ❑ YES ❑ NO
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME	
CITY STATE ZIP	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 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)

PREMIER *medical group*

Date: _____

Patient Name:_____ Date of Birth: _____
E-Mail_____ Phone: _____
Reason for seeing the Dietitian: _____
Referring Physician: _____
Associated Practice: _____
Current Diet Followed:_____
Height:_____
Weight:_____

Please fill out this sheet prior to seeing the dietitian.

Have you experienced any recent weight loss or gain? Y/ N, if yes how much?_____
Have you been diagnosed with Irritable Bowel Syndrome? Y/N
Have you been diagnosed with small intestinal bacterial overgrowth? Y/N
How would you describe yourself? Sedentary Active Very active
If Exercise what do you do? _____
How Often do you exercise?_____
Any diets in the past that you trialed_____

Please Circle any of the following for which you have been tested:

Celiac testing: duodenal biopsy or blood test
Lactose intolerance testing
Fructose malabsorption
SIBO testing
Thyroid levels
Vitamin D levels: if so what is your level?_____
Allergy testing? If so, what type? IgE/Rast test or IgG

Primary Symptoms:
Please circle any of the following symptoms that apply: On a scale of 1-10 (10= terrible, 0=non-existent) please state a number that identifies the level intensity of the following symptoms:

Abdominal pain	Nausea	Dysphagia/ Swallowing
Bloating	Vomiting	Skin itch
Gas	Constipation	Atopic dermatitis
Diarrhea	Reflux/dyspepsia (GERD)	Fecal Incontinence

Based on the above symptoms, how frequently during week or month do your GI symptoms impact your quality of life?

_____
_____
_____

Please list a 24-hour recall of a typical day. List all foods consumed as well as beverages including water.

Breakfast:

Snack:

Lunch:

Dinner:

Snack:

What are your goals?

What questions do you have for the dietitian?

PAYMENTS OF BENEFITS AUTHORIZATION

I hereby authorize payment of all services rendered to me, to be paid directly to Premier Medical Group providing that my insurance company will forward payment directly to them. I understand that regardless of my insurance, I am financially responsible for payment of services rendered to me. I also authorize the release of any information that is needed by my insurance company to process such claims.

Name _____
Signature _____ Date _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain and/or release your records to and from your primary physician and other physicians you are under the care of.
Date _____
Physician/Hospital _____
Address _____
Phone number ( ) _____

ADVANCED DIRECTIVES

Do you have an advanced directive in place? _____Yes _____No
If yes, do you have: ___Living Will ___Power of Attorney ___Healthcare Proxy ___DNR
Custodian of document: _____ Relationship: _____
Please be advised, if you do have any advanced directive, our office is required to obtain a copy for your records.

NO SHOW POLICY

I acknowledge that I was provided a copy of the No Show policy letter from Premier Medical Group.

Print Name: _____
Signature: _____ Date:_____
*If person signing is not the patient, please print your name and relationship to patient:
Name:_____
Relationship:_____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure for Premier Medical Group.

Print Name: _____
Signature: _____ Date:_____
*If person signing is not the patient, please print your name and relationship to patient:
Name: _____
Relationship: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION AND RECORDS TO THE FOLLOWING PEOPLE (PLEASE LIST ANY FAMILY MEMBERS, FRIENDS, OR PHYSICIANS WHO DID NOT REFER YOU):

_____
_____
_____
_____

****IN FILLING OUT THIS FORM, YOU ARE ENSURING THAT WHOEVER YOU HAVE LISTED WILL HAVE THE RIGHT TO YOUR MEDICAL RECORDS/INFORMATION.****

For Office Use Only:
If the patient/representative requested a copy of notice, please provide date copy was given:
Date:_____
If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:

_____
_____

PATIENT TREATMENT/FINANCIAL WAIVER

I, _____ realize that if I do not provide the proper referral or insurance information to cover the services that I am requesting from Premier Medical Group, I will be responsible for the payment of this visit and all associated charges for me or my dependent(s).

Signed: _____

Date: _____

Witnessed: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.