PREMIER *medical group*

PATIENT REGISTRATION FORM PACKET

INSTRUCTIONS:

- Please complete all pages included in this packet.

- Bring the completed paperwork to your scheduled appointment. Do not fax or email it to the office. Additionally, bring the following items with you:
  - All medical insurance cards
  - Photo ID
  - List of medications
  - Any recent lab results and radiology reports

- If your insurance company requires a referral, it is your responsibility to bring the referral with you on the day of your appointment.

- Please note that **all co-pays are due at the time of service**.

- We do not accept Worker's Compensation insurance.

NO-SHOW FEE POLICY

If you do not provide at least 48 hours' notice for the cancellation of your scheduled appointment, a no-show fee may be billed to your account.

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PATIENT ACCOUNT NUMBER

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	PRIMARY PHYSICIAN

Gender Identity (Check One)	Sexual Orientation (Check One)	Pronouns
☐ Identify as Male ☐ Identify as Female ☐ Gender Nonconforming/Nonbinary ☐ Other (Please Specify)_____ ☐ Choose not to disclose	☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something else, please describe _____ ☐ Don't Know ☐ Choose not to disclose	☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other:_____

PATIENTS 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	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** ( )
EMPLOYERS 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	EMPLOYERS NAME	
CITY STATE ZIP	EMPLOYERS 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)

PREMIER *medical group*

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.

Print Name: _____ **Signature**: _____

Address: _____

Date: _____

RECORDS RELEASE AUTHORIZATION

This record release authorization allows us to obtain/release your records to and from your primary physician and other physicians you are under the care of.

Date: _____ **Physician/Hospital:** _____

Address: _____

Phone #: _____

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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: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

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

Print Name: _____ **Date:** _____

Signature: _____

*If the 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 yourself, and family members, friends, or physicians who did not refer you). In filling out this form, I understand that whoever I have listed will have the right to my medical records/information:

_____

_____

FOR OFFICE USE ONLY: *If patient/representative requested a copy of the notice, provide date copy was given: _____. If no acknowledgement could be obtained, state the reason(s) why and the efforts taken to try to obtain the acknowledgment:* _____

PREMIER *medical group*

NO-SHOW POLICY

We understand that there may be times when you need to cancel an appointment. If this occurs, please contact us at least 48 hours before your scheduled appointment time. You can reach us by calling the office or through the patient portal. Timely rescheduling of your appointment allows us to offer that time to another patient in need of care.

If you do not attend your appointment or if you cancel or reschedule within 48 hours of your scheduled time, it will be classified as a no-show. No-show appointments may incur a fee ranging from $50 to $150, as detailed below:

- Holter Monitor- $25.00
- Office Visits - $50.00
- Ultrasound or Xray - $50.00
- Cardiac Testing - $50.00
- Imaging or In-office Procedures - $100.00
- Nuclear Stress Test- $150.00
- Out of Office Procedures - $150.00

This fee is the patient's responsibility and must be paid in full before your next appointment. If the no-show fee could prevent you from receiving necessary care, please reach out to us.

We understand that unexpected situations may occur. In cases of emergencies or extenuating circumstances, we may choose to waive the no-show fee. Such waivers will be evaluated on a case-by-case basis at the discretion of the practice management.

NO-SHOW POLICY ACKNOWLEDGEMENT

I acknowledge that I was provided with a copy of the No-Show Policy from Premier Medical Group.

Print Name: _____

Signature: _____ **Date**: _____

*If the person signing is not the patient, please print your name and relationship to patient:

Name: _____Relationship:_____

PREMIER *medical group*

Nutritionist Patient History Form

Name: _____ DOB_____

Email: _____ Phone: _____

Reason for today's visit: _____

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 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? _____
Past diets you've trialed: _____

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

- ☐ Celiac Testing
  - ☐ Duodenal Biopsy
  - ☐ Blood Test
- ☐ Lactose Intolerance Testing
- ☐ Fructose Malabsorption
- ☐ SIBO Testing
- ☐ Thyroid Levels
- ☐ Vitamin D Levels
  - If so, what is your level? _____
- ☐ Allergy Testing
  - ☐ IgE / Rast Test
  - ☐ IgG

Primary Symptoms:

Please check any of the following symptoms that apply: On a scale from 1-10 (10= Terrible, 0= nonexistent) Please state a number that identifies the intensity level of the following symptoms:

- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Gas
- ☐ Diarrhea
- ☐ Dysphagia/Swallowing
- ☐ Skin Itch
- ☐ Atop Dermatitis
- ☐ Fecal Incontinence
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Reflux/Dyspepsia (GERD)

Based on the above symptoms, how frequently during the 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 dietician?
_____
_____
_____
_____

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:

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