



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.

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

Tel: 1-888-632-6099 | Web: www.premiermedicalhv.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)			PRIMARY PHYSICIAN		
Gender Identity (Check One) <input type="checkbox"/> Identify as Male <input type="checkbox"/> Identify as Female <input type="checkbox"/> Gender Nonconforming/Nonbinary <input type="checkbox"/> Other (Please Specify) _____ <input type="checkbox"/> Choose not to disclose		Sexual Orientation (Check One) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please describe _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose		Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LEGAL REPRESENTATIVE <input type="checkbox"/> YES <input type="checkbox"/> 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)



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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: _____*



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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: _____



Podiatry Patient History Form

Name: _____ DOB _____

Date: _____

Please list the problem(s) that brings you in today: _____

Onset: Gradual____ Sudden____ **Duration:** ____Days ____Weeks ____Months ____Years

Injury: _____ **Type of pain:** _____

Previous Treatment: _____

Surgical History: _____

☐ Tonsils _____ ☐ Gallbladder _____ ☐ Gastric _____

☐ Appendix _____ ☐ Foot _____ ☐ Rectal _____

☐ Hernia _____ ☐ Female _____ ☐ Injuries/Fractures _____

Pain: On____ Off____ **Weight-bearing Footgear:** _____

Please mark any of the following medical conditions that you have ever had:

☐ Diabetes _____ ☐ Ulcers _____ ☐ Rheumatic Fever _____

☐ Cardiac _____ ☐ Cancer _____ ☐ Phlebitis _____

☐ Hypertension _____ ☐ TB _____ ☐ Bleeding Disorders _____

☐ Arthritis _____ ☐ Stroke _____ ☐ HIV/AIDS _____

☐ Epilepsy _____ ☐ Asthma _____

☐ Gout _____ ☐ Kidney _____

☐ Nervous Disorders _____ ☐ Liver _____

☐ Other _____

List any medications you are taking on a regular basis or now: _____

Are you allergic to any of the following:

☐ Penicillin _____ ☐ Aspirin _____ ☐ Codeine _____

☐ Local Anesthetics _____ ☐ Iodine _____ ☐ Tape/Latex _____

Allergic to any food or environmental sources: _____

List any blood relatives with the following conditions:

☐ Diabetes _____ ☐ Foot _____

☐ Gout _____ ☐ Other _____

Do you smoke? Yes____ No____ If yes, How long? _____

Do you drink alcohol? No____ Occasionally____ Regularly____

Do you have history of previous drug abuse? Yes____ No____

Are there any cultural beliefs that might effect the care you receive today? Yes ____ No____

Do you require interpreter services? Yes____ No____