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*

PREMIERMEDICALHV.COM

Phone: (845)437-5000 Fax: (845)452-4314

_____ _____

NOMBRE DEL PACIENTE *FECHA DE NACIMIENTO*

Cual es el motivo de su visita a nuestra oficina Urologica? _____

_____

Cuales son sus sintomas actuales? _____

_____

Usted fue referido a nuestros medicos por otro medico? ☐ **SI** ☐ **NO**

En caso afirmativo, quien le remitio? _____

Telefono: _____ **Fax:** _____

Ha tenido alguna prueba mas reciente? (Analisis de sangre / TAC / Radiografis / Ultrasonidos)

☐ **SI** ☐ **NO** **En caso afirmarivo, donde y cuando se hizo el examen?** _____

_____

MEDICINAS

NOMBRE DE MEDICAMENTO **DOSIS** **CON QUE FREQUENCIA SE LAS TOMA**

_____

_____

_____

_____

_____

_____

Tiene algun de alergia al Latex, Yodo, Contraste IV, Tintes? _____

Tiene alergias a algun medicamento? ☐ **SI** ☐ **NO** **Encaso afirmativo, indique los medicamentos. Si necesita espacio adicional, utilice la parte trasera de esta document o adjuntar una lista.** _____

_____

HISTORIA CLINICA GENERAL

Alguna vez ha sido diagnosticado con cualquier problema de salud, condiciones o han tenido su anterior las cuestiones medicas? _____

_____

Alguna vez ha tenido operaciones quirurgicas? (En caso afirmativo, por favor escribe al ano y por favored incluir cirugias de infancia, si existen

_____

_____

Cualquier inmediato antecedents familiars (padres, abuelos, hermanos) de Cancer de la Vejiga, Cancer de rinon, Cancer de la Prostata or Piedras en los Rinones? ☐ **SI** ☐ **NO**

En caso afirmativo, sirvase indicar que tienen y que miembro de la familia tenia el problema.

_____

Viven sus padres? ☐ **SI** ☐ **NO** **En caso afirmativo, tienen algun problema medico importante? Por favor, explique:** _____

_____

Si sus padres han fallecido, por favor indique la causa del la muerte y su eded en el momento de su muerte? _____

Consume alcohol? ☐ **SI** ☐ **NO En caso afirmativo, con que frequencia?** _____

Cuanto? _____ **Actualmente usan cualquier drog ilicita?** ☐ **SI** ☐ **NO**

En caso afirmativo, que tipo de drogas usas y cuanto duro el uso? _____

Utilizo alguna droga illegal en el pasado? ☐ **SI** ☐ **NO En caso afirmativo, por cuantos anos?** ____

y que tipo de drogas usas y cuando fue la ultima vez que se las tomo? _____

CONSUMO DE TABACO

Utiliza algun tipo de product de Tabaco? ☐ **SI** ☐ **NO En caso afirmativo, por quantos anos?** _____

Que product usa? (Marque las que correspondan)

☐ **Cigarillos** ☐ **Pipa** ☐ **Cigarros** ☐ **Tabaco de mascar**

Con que frequencia utiliza productos de Tabaco? _____

Si lo hace, o fumaba, cuantos paquetes por dia? _____

Si usted es un ex fumador, cuando dejo de fumar? _____

Tienes un historial de entermedades de transmission sexuales? ☐ **SI** ☐ **NO En caso afirmativo, cual es o era la enfermedad de transmission sexual tiene o tenia?** _____

Cuando se le diagnostic? _____

SOLO PARA HOMBRES:

Esta tomando algun medicamento del crecimiento de cabello (por via oral or topical)? ☐ **SI** ☐ **NO**

En caso afirmativo, cual es el nombre del medicamento? _____

Toma algun suplemento de salud de la prostate ya sea prescrito por otro medico o por su cuenta?

☐ **SI** ☐ **NO en caso afirmativo, cual es el nombre del suplemento?** _____

SOLO PARA MUJERES:

Ha tenido partos vaginales o Cesaria? _____

Cuando fue su ultima mamografia? _____ **Prueba de Papanicolao?** _____

INFORMACION GENERAL

Tiene usted una direciva anticipada de Poder? ☐ SI ☐ NO

En caso afirmativo, por favor traiga una copia a su cita, para que podamos teneria como parte du su historial medico.

Estado civil actual: ☐ Soltero ☐ Casado ☐ Divorciado

Tiene usted hijos? ☐ SI ☐ NO En caso afirmativo, cuantos hijos tienes? _____

Esta actualmente empleado: ☐ SI ☐ NO Retirada(o): ☐ SI ☐ NO

En caso afirmativo, cual es o era su ocupacion? _____

Usted ahora o ha estado exuesto a los riesgos ambientales? (Productos, quimicos, toxinas, humo, etc.)

☐ SI ☐ NO En caso afirmativo, lo que esta or estuvo expuesto? _____

Gracias por completar el formulario.