New Patient Registration Form Please fill out Completely

FULL LEGAL NAME (Last, First, Initial) ____(Nickname)__________

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-________ SEX (M / F)

MARITAL STATUS______________

MAILING ADDRESS____

CITY ______________________ STATE ______________ ZIP CODE __________________

HOME PHONE # ________________________ CELL PHONE #__________________

EMERGENCY CONTACT & PHONE ____

EMPLOYER INFORMATION:

COMPANY NAME ____

WORK PHONE ________________________ EXT ________

ADDRESS ____

CITY ________________________ STATE _____ ZIP CODE _____________

SPOUSE'S INFORMATION:

FULL LEGAL NAME ____

WORK PHONE ________________________ EXT ________

OCCUPATION __________________ EMPLOYER NAME ________________________

CELL PHONE ________________

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) ____________________________

ADDRESS ____

CITY ________________ STATE ____ ZIP _________

RELATIONSHIP ________________________

DATE OF BIRTH __/____/______ PHONE NUMBER ______________________

INSURANCE INFORMATION/WORKERS COMP INFO:

Please give your card to the receptionist to copy

IS CONDITION RELATED TO EMPLOYMENT?________ AUTO ACCIDENT?_______ OTHER ACCIDENT?________

DATE OF INJURY ______________________ TIME OF INJURY _____________________________

INSURANCE ____

SUBSCRIBER NAME ____

RELATIONSHIP________________________

POLICY # ___________________ GROUP # ______________________________

SUBSCRIBER DATE OF BIRTH (IF DIFFERENT THAN SELF) ___/___/______

SOCIAL SECURITY # _______-_____-_______

I authorize that I am responsible to seek the information necessary to process my claim with my insurance company. (REQUIRED) Signature_____________________________ Date ___________	I authorize that I may seek payment of medical benefits for services provided by Health Quest . (REQUIRED) Signature__________________________ Date ____________

The patient acknowledges that tall of the above information is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services including all costs of collection and a reasonable attorney's fee should collection become necessary. The patient also acknowledges receipt of Privacy Policy.

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Signature of Patient

____Date_____________

Name Printed in full

Contact Information

I understand that during my treatment here at Health Quest Family Medicine, the physician or staff may need to contact me in order to relay important information about my medical treatment and care.

I prefer to be contacted at:

_____ home number: ______________________________

_____ cell phone number: ______________________________

_____ work number: ______________________________

_____ fax number: ______________________________

_____ other: ______________________________

If I am not home or unable to receive necessary information, I, ______________________ , give my consent to the staff of Health Quest Family Medicine to leave confidential information about my care to:

_____ my answering machine

_____ spouse/significant other: ______________________________ (name and phone number)

_____ other: ____ (name and phone number)

I understand that if my preferences change or any phone number changes, I need to notify Health Quest Family Medicine.

Print name: __________________________________ Date of birth: ______________

Signed: _____________________________________ Date: ____________________

Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you , your health and you health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made buy your personal physician or others working in the office. This notice will tell you about the ways in which you may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identities you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose your PHI

The following categories describes different ways that we use and disclose health information

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatments including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. A third party may request payment/reimbursement from you for your treatment.

Appointment Reminders: We may use and disclose heath information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military or local law.

To Avert Serious Threat to Health or Safety: We will disclose health information about you when necessary to prevent a serious threat to the health and safety of your and other individuals

Workers Compensation: We may release health information about you for workers" compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to the coroner, health examiner, or funeral directors as necessary to carry out the duties.

Patients Rights Regarding Medical Records

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a feel for the costs or copying, mailing, or other supplies and services associated with your request. We may deny your request to inspect and copy in certain and very limited circumstances. If you are denies access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conduction the review will not be a person who denied your request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment. If it is not a part of the health information kept by or for our practice. If it is not part of the information that you would be permitted to inspect and copy.

Patient Financial Responsibility

Providing the highest quality of medical care for our patients is our primary concern. By not participating within the managed care system, we are able to provide you with the care that you deserve. All office and home visits must be paid that the time of service. For your convenience we accept cash, debit, credit and checks. You are responsible for contacting your insurance carrier for reimbursement at the non contracted physician rates. We are not responsible for submission and collection of your fees that are charged in the office. We are more than willing to provide you with the information needed for you insurance carrier. Please ask if you would like the appropriate forms for reimbursement from you insurance carrier.

Patient's Bill of Rights

As a patient of Health Quest Family Medicine, you have the right, consistent with Arizona State law, to:

1. Understand and use these rights. If for any reason you need help with this, we will provide assistance.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or sexual orientation.
3. Receive considerate and respectful care in a clean and safe environment.
4. Be informed of the name and position of the health care provider who will be in charge of your care.
5. Know the name, position, and function of any staff involved in your care and refuse treatment, examination, or observation by that person.
6. Receive care in a non-smoking environment.
7. Privacy and confidentiality of all information and records regarding your care.
8. Participate in all decisions about your treatment.
9. Refuse treatment, examination or observation and be told what effect this may have on your health.
10. Obtain a copy of your medical record within a reasonable period of time.
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Receive all the information you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
13. Receive urgent care if you need it.
14. Complain without fear of reprisals about the care and services you are receiving and to have Health Quest Family Medicine respond to you and, if you request it, provide you with a written response. If you are not satisfied with the response, Health Quest Family Medicine must provide you with the telephone numbers of alternate physicians so that you may transfer your medical care.

Patient's Responsibilities

The staff of Health Quest Family Medicine strives to provide you, the patient, with the best care possible. Below are some things you can do to help us achieve that goal:

- Arrive on time for scheduled appointments. If you will not be able to make a scheduled appointment, please call and cancel it so that another student may be scheduled in your place.
- Give your health care provider all the information she or he will need to determine the best treatment for you: fill out any forms completely and accurately; tell your provider about past and current diagnoses and treatments, such as past illnesses, hospitalizations, and medications; and be as clear as you can about current symptoms, including pain and/or psychological stress.
- Provide correct and complete contact information.
- Be open and honest with your health care provider if you do not understand or cannot comply with instructions you are given.
- Call your health care provider promptly if your condition worsens or does not follow the expected course.
- Check with your provider well before you run out of your current supply of prescription medication.
- Use prescription and over-the-counter medications as directed. You should never share medication prescribed for you with others.
- Treat fellow patients and Health Quest Family Medicine staff with the same courtesy and respect that you expect from them. Please respect others' right to privacy as you would ask that your own be respected.
- Make use of information available through the materials in our waiting rooms and on our website. You can make your experience at Health Quest Family Medicine more satisfying by understanding the way appointments are scheduled, the resources available for after-hours care or emergencies. You may also find information that is helpful to understanding your health care needs on our website www.thehealthquest.com.

BY SIGNING BELOW I ACKNOWLEGE I HAVE READ AND UNDERSTAN THE FOLLOWING POLICIES AND I ACCEP THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Confidentiality and Privacy of Medical Records
- Patient's Bill of Rights
- Patient's Responsibilities

____________________________________ ____________

Patient Signature Date

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Patient Printed Name