REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's legal last name:	Patient's legal first name:	Middle:
Former (maiden) name:	Birth Date:	Sex: ☐ M ☐ F

Mailing Address: [Address/P.O Box, City, ST ZIP Code]
Physical Address: [Address/P.O Box, City, ST ZIP Code]

Marital status:	Social Security number:
Home phone number:	Cell phone number:

Employment status:	Employer:	Employer phone number:

Referred to clinic by (Please choose one option):

☐ Doctor's Name: ☐ Other: (Insurance, Family/Friends, Close to home, Etc.)

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:
Home phone number:	Work phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am finically responsible for any balance. I also authorize Pioneer Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date:

My signature acknowledges I have received or have been offered a copy of Pioneer Medical Center's **"Notice of Privacy Practices".**

____________________________________ Date ________________________
Signature of patient or patient's representative

Printed name of patient ____

Printed name of patient's representative ________________________________

Relationship to patient ____

USE /RESTRICTION OF PATIENT INFORMATION

In general, the HIPPA privacy rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home telephone ____________________

O.K. to leave message with detail information
Leave message with call-back number only

Work telephone ____________________

O.K. to leave message with detail information
Leave message with call-back number only

Cell phone ____________________

O.K. to leave message with detail information
Leave message with call-back number only

Written communication

O.K. to mail to my home address
O.K. to mail to my work/office address
O.K. to fax to this number ____________

Verbal communication

O.K. to release information verbally to

____
____
____
____

It is the patient's responsibility to provide updates or changes to this information.

____________________________________ Date ________________________
Signature of patient or patient's representative

The Privacy Rule generally requires health providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment, Payment, and Healthcare Operation (TPO) may be permitted without prior consent in an emergency.

CANCELLATION AND NO SHOW POLICY AGREEMENT

Policy:

If you are unable to keep your scheduled appointment, we ask that you please call the Clinic by 4:00pm the day before your appointment to reschedule your appointment.

If missing appointments becomes problematic and habitual (determined by missing a total of 4 appointments - i.e. no shows or cancellations the same day of the appointment in a 6 month period) PMC reserves the right to discharge you from the Pioneer Medical Clinic, wherein we would provide you with 30 days to find a new provider. However, you would still be able to access the Emergency Room if any emergencies should arise.

Why this Policy Exists:

This policy exists to ensure we are providing patients with convenient appointment times while also discouraging those individuals that consistently fail to keep their appointments. When a patient fails to arrive for an appointment or cancels the same day, it creates missed opportunities for other patients that may have preferred that time slot. We understand that things come up last minute and are happy to accommodate you, but ask that you let us know as far in advance as possible to better assist other patients.

Out of respect for other patients being seen, if you are more than 15 minutes late for your appointment, you may be asked to reschedule your appointment for another time.

Thank you for your cooperation and understanding.

__________________________________ _________________

Signature Date