# Richard D. Adelman, M.D.

Family Health Care
7320 Six Forks Rd., Ste 260
Raleigh, NC 27615

**PATIENT REGISTRATION FORM** Date_____/_____/_____

Name ____________________________________________ Sex ________
Last First Middle

Address ________________________________________
Street Apt #

________________________________________
City State Zip code

SS# ____________________ Age ______ M ____ F ____ Birthdate (mm/dd/yyyy) ______/______/______

Marital Status (circle one) M S W D Sep Race: __________ Ethicity Hispanic Non-Hispanic

Phone # __________________ Cell # __________________ Bus # __________________

**Preferred Method of contact** Home _____ Cell _____ Bus _____ Mail _____ E-Mail ______

**e-mail address** ____________________

Responsible Party: ______________________________ Home # ________________
Last First Middle

Address ________________________________________
Street Apt # City State Zip Code

Employer of Responsible Party __________________________ Bus. Phone # ________________

Address ________________________________________
Street City State Zip Code

Responsible Party SS# ____________________ Date of Birth (mm/dd/yyyy) ______/______/______

**Insurance Information**

**Primary Insurance**

Name of Insurance:____________________ ID# ____________________Grp# __________

Policy Holder: ________________________ DOB______/______/______

**Secondary Insurance**

Name of Insurance ____________________ ID# ____________________Grp# __________

Policy Holder: ________________________ DOB ______/______/______

**Authorization to Release Information**

I hereby authorize my Physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collections of my claims.

Signature:______________________________ Date: ______________

**Acknowledgement of Privacy Practices**

I hereby acknowledge that I have received a copy of Richard D Adelman, MD, Family Health Care Notice of Privacy Practices that describes how information about me may be sued or disclosed, in accordance with HIPPA (Health Insurance Portability and Accountability Act).

Signature: ______________________________ Date: ______________

**Emergency Contact Information**

Name: ______________________________ Relationship: ______________

Home # __________________ Cell # __________________ Work # __________________

Name: ______________________________ Relationship: ______________

Home # __________________ Cell # __________________ Work # __________________

## MEDICAL HISTORY

Date ________________

Name ______________________________________________ Birthdate(mm/dd/yyyy)________________

**CURRENT MEDICAL PROBLEM(S)**

| | Date of Onset |
|---|---|
| 1 | |
| 2 | |
| 3 | |

**Occupation** ____________________

**Last Tetanus** ________________

**Have you had Chickenpox** ____ **yes** _____ **no**

**HOSPITALIZATIONS** (include all surgeries, birth of children etc.)

| Date | Hospital | Location | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICATIONS** (List Prescription, Non-Prescription, Herbal Supplements)

| Name | Reason for Medication | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**ALLERGIES** (Medications, foods, pollens, etc) ______________________________________________

______________________________________________________________________

**FAMILY HISTORY (List family members)**

| | Living/ Age | Deceased/ Age & cause of death | List any chronic health problems |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Children | | | |
| Children | | | |
| Children | | | |
| Children | | | |
| Siblings | | | |
| Siblings | | | |
| Siblings | | | |
| Siblings | | | |

Substance Abuse ______________________ Living Will/Advance Directives/HCPOA ________Yes ________No

Exercise ________ x per Week Smoke ______ Packs per Day Alcoholic Drinks ______ per Day

Richard D Adelman, MD
7320 Six Forks Rd., Ste 260
Raleigh, NC 27615
Ph-919-846-9292
f-919-848-3638

Authorization for disclosure of health information and direct

**Our Privacy Policy**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, we understand that we have, and always will, respect the privacy of your health information.

**Disclosures of protected health information**

There are several reasons for having to use or disclose your PHI(personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and/or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

**Your right to limit uses or disclosure**

- You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of disclosure of your PHI, we will respectfully request that you submit these restrictions in writing.

We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form. (164.520)

I acknowledge that I have been offered to review a copy of the practice's Notice of Privacy Practices.

Patient Signature ______________________________ Date __________

Print Name ______________________________ Date of Birth ______________

# PATIENT FINANCIAL POLICY

Dear Patient:

We are pleased you have chosen Dr. Adelman as your family physician. As he provides the quality medical care you need, we, his office staff, will work with you in arranging convenient appointments as well as assisting with processing of your health insurance. As you know, medical insurance and payments can become quite complicated at times. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we accept Visa and MasterCard, as well as personal checks and cash.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have a contract and will only require you to pay the deductible or co-pay at the time of service. Please be prepared to pay your co-payment when you arrive for your appointment.

- If you have insurance coverage with a plan with whom we do not have a contract, we will provide a claim form delineating the physician's services for you to forward to your insurance company. Your insurer will send payment directly to you, therefore, our charges for your care and treatment are due at the time of the service.

- All health plans are not the same and do not cover the same services. In the event your carrier determines a service to be "not covered", you will be responsible for the complete charge. If you are covered by Medicare, you will be notified in advance and asked to sign a waiver. Payment is due upon receipt of a statement from our office.

- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and we will bill you for these balances.

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. For convenience, Dr. Adelman and staff may apply payment of my account from my MasterCard/Visa upon my request.

________________________________________________________

Signature of Patient or Responsible Party if a Minor Date

________________________________________________________

Please Print the Name of the Patient

**Patient Consent for Use and Disclosure of Protected Health Information**

Richard D. Adelman, MD

With this consent I give permission to the practice of Richard D Adelman, MD to obtain my current medication history from other providers I am seeing.

_______________________________
Signature of Patient or Legal Guardian

_______________________________ ____________________
Print Patient's Name Date

Richard D Adelman, MD
7320 Six Forks Rd., Ste 260
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Phone – 919-846-9292
Fax – 919-848-3638

## Authorization for Use or Disclosure Of Protected Health Information

I hereby authorize the practice of ______________________________
at ______________________________
to convey to **Richard D Adelman, MD** any and all information that he/she possesses relative to my medical records. This is to include all office notes, labs and test results.

_______ Information contained in the patient's medical record MAY relate to
initial psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.

_______ Information contained in the patient's medical record MAY relate to AIDS
initial or HIV infection, treatment for alcohol and/or drug abuse, and or genetic testing

Please release only the following information for specific dates to the above practice

______________________________

______________________________

______________________________

I direct and hereby authorize the practice of Richard D Adelman, MD to deliver the Protected Health Information specified in this authorization to the party or parties specified in the following format, if available:

___ Hardcopy, (paper) ___ E-mail (not recommended)
___ CD-ROM or Flash Drive ___ No format preference

I give permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire after **90** days after the date signed. The requestor should not re-disclose my medical records to another party without further written consent.

Patient Name: ______________________________

Signature: ______________________________
(patient /guardian)

Date of Birth: ______________ SS# ______________

Date: ______________________________

Date records sent: ______________ by: ___hardcopy ___flash drive ___CD-ROM
Sent by: ______________________________