PATIENT REGISTRATION FORM

Richard D. Adelman, MD Family Health Care
7320 Six Forks Rd. Ste. 260 Raleigh, NC 27615
p (919) 846-9292 f (919)848-3638

Date_____/_____/_____

Name _____
Last First MI

Address _____
Street Apt #

_____
City State Zip code

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Social Security Number: _____

Primary Phone Number: _____ Secondary Phone Number:_____

Email Address: _____ Method of Contact (circle one): Phone call Text Message

Marital Status: _____ Race: _____ Ethnicity (circle one): Hispanic Non- Hispanic

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

How did you hear about our practice? _____

Do you have a Living Will? _____ Healthcare Power of Attorney? _____ (if yes, please provide a copy)

Emergency Contact Name: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

Guarantor Information

Responsible Party: _____ Phone Number: _____
Last First MI

Address _____
Street Apt # City State Zip Code

Social Security Number: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____

Employer Name _____ Phone Number: _____

Address _____
Street City State Zip Code

Insurance Information

Primary Insurance

Name of Insurance: _____ ID# _____Group# _____

Policy Holder: _____ Date of Birth _____/_____/_____

Secondary Insurance

Name of Insurance _____ ID# _____Group# _____

Policy Holder: _____ Date of Birth _____/_____/_____

MEDICAL HISTORY Date _____

Name _____ Birthdate (mm/dd/yyyy) _____

Address _____

CURRENT MEDICAL PROBLEM(S)	Date of Onset
1	
2	
3	
4	
5	
6	

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. Check all applicable illnesses)

	DM	Arthritis	Asthma	Allergy	Heart	COPD	Stroke	HTN	Anemia	Cancer (type)	Mental/ Emotional	Alcohol	Age of Death
Spouse													
Children													
Mother													
Father													
Siblings													
Grandparents													

DM = Diabetes Heart = Heart Failure, heart attack COPD = Emphysema HTN= high blood pressure

Substance Abuse _____ Living Will/Advance Directives/HCPOA _____Yes _____No

Exercise _____ x per Week Smoke _____ Packs per Day Alcoholic Drinks _____ per Day

Patient Consent for Use and Disclosure of Protected Health Information

Richard D. Adelman, MD

I hereby give my consent for Richard D. Adelman, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Richard D. Adelman, MD's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Richard D. Adelman, MD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard D. Adelman, MD Attention: Melony Lunsford at 7320 Six Forks Rd., Ste. 260, Raleigh, NC 27615.

With this consent, Richard D. Adelman, MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Richard D. Adelman, MD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Richard D. Adelman, MD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Richard D. Adelman, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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.

By signing this form, I am consenting to Richard D. Adelman, MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Richard D. Adelman, MD may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Richard D. Adelman, MD Family Health Care
7320 Six Forks Rd. Ste. 260
P (919-846-9292) F (919-848-3638)

Financial Policy

We are pleased you have chosen Richard D. Adelman, MD as your family's medical provider. We are committed to building a successful provider-patient relationship with you and your family. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policy as an essential element of your care and treatment.

- You are expected to have your insurance card with you at every visit.
- If we are contracted with your current insurance, we will submit an insurance claim on your behalf and collect any copays, deductibles and/or coinsurance at the time of service.
- Copays and past due balances will be collected at the time of service either at check- in or check- out. We will not bill you for copays' unless you have made previous arrangements with the provider or a member of the billing staff.
- In the event that your health insurance determines a service to be "not covered", you will be responsible for the balance. If you are covered by Medicare, you will be notified in advance and asked to sign an Advanced Beneficiary Notice.
- For all services provided to minor patients and/ or patients with guardians, the balance becomes the guarantor's responsibility.
- If we are out of network with your insurance and your insurance company pays you directly for those services, you are responsible for payment and agree to forward that payment to us immediately.

By signing below, you agree to accept full financial responsibility as a patient receiving medical services, and are the responsibility for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party Name: _____

Responsible Party Signature: _____Date: _____