Fall River Medical
Patient Registration Form

fallrivermedicine@gmail.com

Patient Name:_____ Male_____ Female_____
Birth Date:_____ Social Security Number:_____
Mailing Address w/ Apt # :_____
City:_____ State:_____ Zip:_____ Phone: (_____)_____
E-mail Address: _____ Single Married Divorced Widowed
Would you like to be web enabled (access to our online portal, which contains some of your visits and test results)?
Yes ____ No_____

Responsible Party Information: Billing Information
(Whoever takes care of statement after insurance)

Name:_____ Relationship to Patient:_____
Birth Date:_____ Social Security Number:_____
Mailing Address:_____
City:_____ State:_____ Zip:_____ Phone: (_____)_____

Insurance Information: **Is this a State Medicaid Plan? _____yes _____no**

Insurance Company Name:_____
Policy Number:_____ Group Number:_____
Claims Address:_____
Phone Number:_____
Policy Holder's Name:_____**DOB**_____ **Relationship to Patient:**_____
Policy Holders Address:_____
City:_____**State:**_____**Zip:**_____ **Policy Holder Phone:**_(_____)_____
Co-Pay $_____

Secondary Insurance **Is this a State Medicaid Plan: _____yes _____no**

Insurance Company Name:_____
Policy Number:_____ Group Number:_____
Claims Address:_____
Phone Number:_____
Policy Holder's Name:_____**DOB**_____ **Relationship to Patient:**_____
Policy Holders Address:_____
City:_____**State:**_____**Zip:**_____ **Policy Holder Phone:**_(_____)_____
Co-Pay $_____

Emergency Contact:

Name: _____ Phone: (_____)_____
(Phone # must be different than patients phone #)
Relationship to Patient: _____ How did you hear about us? _____

Fall River Family Medicine & Urgent Care

Patient_____

Patient Gaurdian_____

Thank you for choosing Fall River Family Medicine & Urgent Care as your provider. We are committed to excellent patient care. Please read and sign the following information prior to your evaluation today.

Release

- I hereby authorize Fall River Medical to obtain any necessary medical information from any facility or doctor that will help in my diagnosis and care.
- I authorize Fall River Medical to authorize any insurance/benefit to be paid directly to Fall River Medical.
- I authorize Fall River Medical to release any information to my insurance company in order to process my claim.

Consent of Treatment

- I authorize Fall River Medical providers and staff to provide me with any and all necessary evaluations, therapies and/or treatments.

Financial Policy

- I hereby agree to pay the full requested balance to Fall River Medical and any other healthcare professionals involved in my care, such as hospital services.
- I understand that Fall River Medical will bill my insurance company as a courtesy, this does not release me from being responsible for accrued charges.
- I agree to pay all deductibles, co-pays, co-insurances, non-covered services, any charges above reasonable and customary for insurance companies that we are not contractually bound, and all claims that are denied for medical necessity or any other reason.
- I understand that the option exists to form a payment plan with the billing staff of Fall River Medical.
- I understand that my account may be turned over to a third party collection service if these terms are not kept, and will result in additional collection fees.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS IN THE ABOVE SAID POLICY

_____

Authorized Signature Date

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Fall River Medical and any other healthcare professionals involved in my care, (HCFA Form CMS-1500 12-90). I also release any information needed from any source to the Health Care Financing Administration in order to determine correct benefits payable.

_____

Authorized Signature Date

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Fall River Medical P.L.L.C.

Effective March 26, 2013 revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient information. The following summarizes the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment and health care operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.
We are also permitted to disclose your PHI in compliance with the guidelines outlined by law and when required to do so by various government agencies, we may also disclose your PHI to family members, relatives or close personal friends when the information we disclose is relevant to the individual's involvement with your care or is required to assist in your health care (e.g. pick up prescriptions or other documents, notes for follow up care and instructions, ect.) We will disclose your PHI when we refer you to other physicians or providers of healthcare. Finally, we reserve the right to change the privacy practices described in this notice as may be permitted or required by law and to make such changes effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of the PHI be amended. However, our practice is not obligated to agree to request restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive an accounting of disclosures of your health information.

Authorization

Our practice will make other uses and disclosures of your protected health information ONLY after obtaining your written authorization.
If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you want to revoke your authorization.

I authorize the following people to have access to my medical records.

Name: _____ Relation: _____
Name: _____ Relation: _____

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting our office administrator, 21 Winn Dr, Rexburg, Id 83440, or by phone (208) 881-5222. You may also contact the secretary of the department of health and human services. No individual will be retaliated against for filing a complaint.

Acknowledgment

I acknowledge that I have received this summary and copy of the notice of practices regarding the disclosure of my private health information.

Patient OR Guardian Signature: _____ **Date:** _____

I hereby give authorization for payment of insurance benefits to be made directly to Fall River Medical P.L.L.C., and any assisting physicians for services rendered. And that I am responsible for any unpaid portion after my insurance has processed the claim. I understand payment is due at the time of service for private pay, co-ins, co-payment, and deductible if applicable. And that I may receive a separate bill for Labs or Radiology or another entity. I authorize the treatment of the above listed patient by a provider at Fall River Medical P.L.L.C. and any other healthcare professionals involved in my care (hospital services). I agree that a photocopy of this agreement shall be valid as the original.

I understand that I may be seeing a Physician Assistant (PA) for my medical issue and that I have the choice of seeing a physician at another time when an appointment is available.

Patient OR Guardian Signature: _____ **Date:** _____