REGISTRATION

DATE: ____________________

IF MINOR, PERSON RESPONSIBLE FOR PATIENT AND CHARGES ____

RESPONSIBILE PARTY DOB ____________ RESPONSIBILE PARTY SOCIAL SECURITY NUMBER ________________

PATIENT INFORMATION:

PATIENT LAST NAME____________________FIRST____________________MIDDLE____________________

DOB____________RACE ________ SEX________ SOCIAL SECURITY NUMBER________________________

ADDRESS__________________________CITY____________________STATE_________ZIP CODE_________

HOME PHONE_____________________CELL PHONE____________________WORK PHONE________________

EMPLOYER________________________MARITAL STATUS_____________EMAIL________________________

EMERGENCY CONTACT_____________________PHONE_________________RELATIONSHIP________________

PREFERRED PHARMACY__________________________PHARMACY STREET____________________________

PHARMACY CITY AND STATE__________________________________PHONE_________________________

PRIMARY INSURANCE COMPANY____

CONTRACT NUMBER________________________________GROUP NUMBER__________________________

SUBSCRIBER NAME_________________________________SUBSCRIBER DOB_________________________

RELATIONSHIP TO PATIENT___________________________SUBSCRIBER EMPLOYER____________________

SOCIAL SECURITY NUMBER___________________________

SECONDARY INSURANCE COMPANY____

CONTRACT NUMBER________________________________GROUP NUMBER__________________________

SUBSCRIBER NUMBER______________________________SUBSCRIBER DOB_________________________

RELATIONSHIP TO PATIENT___________________________SUBSCRIBER EMPLOYER____________________

SOCIAL SECURITY NUMBER___________________________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO TREATMENT AND TESTS BY RAINES FAMILY MEDICINE PROVIDERS AND STAFF. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE RAINES FAMILY MEDICINE OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

PATIENT/GUARDIAN SIGNATURE: _______________________________DATE_______________________

PRINTED PATIENT/GUARDIAN NAME: _________________________________

Name: ______________________ DOB: ______________________ Date: ______________________

Past Medical History ❑ NONE

❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial Fibrillation
❑ Blood Clots
❑ Cancer
❑ CHF
❑ COPD
❑ Emphysema
❑ Depression
❑ Diabetes
❑ Drug Abuse
❑ Glaucoma
❑ GERD
❑ Gout
❑ Heart Attack
❑ Heart Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV
❑ Kidney Disease
❑ Mental Illness
❑ Migraines
❑ Obesity
❑ Peripheral Artery Disease
❑ Osteoporosis
❑ Seizures
❑ Sleep Apnea
❑ STD
❑ Stroke
❑ Thyroid Disease
❑ TIA
❑ Other ______________________

Give Date of Last: Menstrual Period __________. Chemotherapy __________. Radiation __________.

Surgical History ❑ NONE

❑ Appendectomy
❑ Back Surgery
❑ Bone Surgery
❑ Brain Surgery
❑ Cesarean Section
❑ Coronary Artery Graft
❑ Eyes
❑ Gallbladder
❑ Gastric Bypass
❑ Heart Stent
❑ Hysterectomy, Abdominal
❑ Inguinal hernia repair
❑ Intestinal/Rectal Surgery
❑ Knee Surgery
❑ Lung Surgery
❑ Mastectomy, Left
❑ Mastectomy, Right
❑ Neck Surgery
❑ Pacemaker,Cardiac
❑ Sinus Surgery
❑ Splenectomy
❑ Thyroidectomy
❑ Tonsillectomy
❑ Transplant
❑ Wisdom Teeth
❑ Other ______________________

Family History

Does your Mother have: ❑ Living ❑ Deceased - Cause of Death ______________________

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Cancer
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Mental Disease
❑ Thyroid Disease
❑ Seizure
❑ Stroke
❑ Mental Illness
❑ Other ______________________

Does your Father have: ❑ Living ❑ Deceased - Cause of Death ______________________

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Cancer
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Mental Disease
❑ Thyroid Disease
❑ Seizure
❑ Stroke
❑ Mental Illness
❑ Other ______________________

Do your Children or Siblings have - Please Specify:

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Cancer
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Mental Disease
❑ Thyroid Disease
❑ Seizure
❑ Stroke
❑ Mental Illness
❑ Other ______________________

Social History

Tobacco Status	❑ Never Smoked	❑ Current Smoker	❑ Former Smoker	Packs per Day ____
Alcohol Drinks	❑ Never	❑ Daily	❑ Weekly	❑ Monthly
Illegal Drug Use	❑ Never Used	❑ Current User	❑ Former User	

Current Medications (attach additional page if needed)	Dose	Frequency

Drug Allergies	Reaction
No known drug allergies mark the box ❑	

FINANCIAL ACKNOWLEDGEMENTS AND OFFICE POLICIES

INSURANCE INFORMATION: Raines Family Medicine accepts most insurance payers. As a courtesy, we will file your medical claims for you. However, it is your responsibility to check with your insurance plan to advise you on your coverage. Most plans are specific to your employer group and we do not know what a covered benefit is under your plan. Your employer benefit advisor at your place of employment will be able to answer your questions regarding your coverage and benefits. It is your responsibility to ensure that our providers are covered under your health plan.

It is your responsibility to provide accurate and updated insurance information at each visit. You will be responsible for any balance that your insurance carrier denies as a result of inaccurate information. Please check with our receptionist at each visit to verify if we have the most up to date insurance information and card on file.

You are ultimately responsible for payment of charges for services that you receive from our office. If your claim is denied or payment is made within thirty (30) days from the date of service, you must contact your insurance plan for an explanation and pay us any amounts not covered by your health plan. It is important that you go over your insurance company's explanation of benefits concerning billing questions prior to contacting our office concerning a bill from Raines Family Medicine.

LABORATORY SERVICES: Many insurance plans now require you to go to or send your lab specimens to specific laboratories. Please let us know if this is the case. Raines Family Medicine does have a lab on site and some tests may be performed here while other tests must be referred to an outside laboratory.

MISSED APPOINTMENTS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve a specific time for your care and we make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a 24 hour notice is required. If you **DO NOT** contact us before the 24 hour window, whether in person, phone, voicemail or email, it will result in a $25.00 fee assessed on your account. If you are **15 minutes** late for an appointment, the provider will determine if you can be seen or your appointment may need to be rescheduled. Any appointments later than **30 minutes** will have to be rescheduled.

METHOD OF PAYMENT: We accept all major credit cards, debit cards and cash. **We do not accept checks.**

COPIES OF MEDICAL RECORDS: Medical records request must be received at least five (5) business days prior to the date needed. There is no charge for records provided from doctor to doctor. There is a charge for records requested by the patient or other parties.

Forms for disability, handicap parking, workers' compensation, medical leave, insurance authorization for brand or non-formulary drugs, medical releases, letters for employers, school, health clubs, etc., may be subject to an administration fee of $25.00.

My signature below indicates that I have read and understand the Financial Acknowledgement and Financial Policy and accept these terms. My acceptance covers my visit today and all future visits.

____ ____________________

Signature of Patient or Legal Guardian Date

PATIENT CONSENT FOR MEDICAL TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that I have the right to make informed decisions about my health care treatment. I agree to have the providers and staff perform tests and treatments they feel are needed for my care. These may include lab tests, vital signs, medications, and other therapy. I know other treatments and tests that have more risk will be explained to me so I can give informed consent for them if I need them. I know I can ask my doctor any questions I have about my treatment.

I hereby give my consent for Raines Family Medicine to use and disclose protected health information about me to carry out treatment, payment and health care operations. Raines Family Medicine's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review Raines Family Medicine's Notice of Privacy Practices prior to signing this consent. Raines Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Raines Family Medicine at 3731 Rainbow Drive Suite B Rainbow City, AL 35906.

With this consent, Raines Family Medicine may call my home, send e-mail, text or mail to my home or other alternative location, and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations. These items include, but are not limited to: appointment reminders, insurance items, correspondence from medical and/or nursing staff, calls pertaining to clinical care, including laboratory results, and billing statements.

I have the option to request that Raines Family Medicine restrict how it uses or discloses my personal health information to carry out treatment, payment and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Raines Family Medicine's use and disclosure of my personal health information to carry out treatment, payment and health care operations with those organizations and health providers necessary for my medical care.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don't not sign this consent, or later revoke it, Raines Family Medicine may decline to provide treatment to me.

______________________________ ______________________________

Signature of Patient or Legal Guardian | Printed Patient Name

______________________________ ______________________________

Patient's Date of Birth | Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (HIPAA)

This office has a policy to keep patient information confidential. You may designate below if you want someone other than yourself to have access to your private health information.

PATIENT NAME: ____DOB:______________________

Release of medical information to person (s) other than myself:

I allow the following people to receive and/or discuss medical information about my condition at any time:

___________________________________Relationship to patient: ______________________________

___________________________________Relationship to patient: ______________________________

___________________________________Relationship to patient: ______________________________

Signature____ Date_______________________

ACKNOWLEDGEMENT OF E-MAIL STATEMENTS

I understand that it is Raines Family Medicine's policy to send my statements to my current e-mail address.

By signing this form I am giving my consent to accept my statements via e-mail. I may opt out at any time by notifying the office in writing.

Email Address____

Signature____Date_______________________

RAINES FAMILY MEDICINE

3731 RAINBOW DRIVE SUITE B

RAINBOW CITY, AL 35906

PHONE: 256-442-1834 FAX: 877-991-4819

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Information (Please Print):

Name: ______________________________ Date of Birth: _____/_____/______

Address: ____

City: ___________________________ State: ____________ Zip: ____________

Telephone Number: (______) _______-__________

Please Release My Medical Records From:

Name of Provider: ____

Address: ____

City: ___________________________ State: ____________ Zip: ____________

Telephone Number: (______) _______-__________

Fax Number: (______) _______-__________

To:

Dr. J. Matt Raines

3731 Rainbow Drive Suite B

Rainbow City, AL 35906

Phone: 256-442-1834 Fax: 877-991-4819

Please release the following records: □all records □ progress notes □ lab results

□ x-ray reports □ H&P □ Discharge Summary □ Op-Note □ Cardiac Work-up

□ Other_____________________________

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patient's Signature: ______________________________________Date: ____________

Witness Signature: ______________________________________Date: ____________