PATIENT REGISTRATION

Please print and complete all parts Chart No:_____

Have you or any family member been treated by Dr. Storms? ❑Yes ❑No Name: _____

PATIENT

Patient Name: _____ Age: _____
Nickname

Race (Circle One): African American Asian Caucasian Mexican American Other: _____ Ethnicity:_____

Language:_____ Social Security #_____ Maiden/Former Name:_____

Sex: ❑M ❑F Date of Birth:_____ Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Home Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

E-mail Address:_____

Employer:_____ Occupation:_____

Employer Address:_____ Work Phone:_____

City:_____ State:_____ Zip Code:_____

Primary Care Physician: _____PCP Phone: _____

Address:_____

How did you hear about our office?: ❑Radio ❑TV ❑ Newspaper ❑Web ❑Phonebook

❑Doctor (_____) ❑NP / PA (_____) ❑Other (_____)

RESPONSIBLE PARTY

Primary Insurance:_____	Secondary Insurance:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
ID#:_____ Group#:_____	ID#:_____Group#:_____
Insured's Name:_____	Insured's Name:_____
Insured's SSN:_____	Insured's SSN:_____
Insured's Birth date:_____	Insured's Birth date:_____
Relationship to Patient:_____	Relationship to Patient:_____
Insured's Employer:_____	Insured's Employer:_____
Employer Address:_____	Employer Address:_____
_____	_____
Employer Phone:_____	Employer Phone:_____
City:_____ State:_____ Zip_____	City:_____ State:_____ Zip_____

Emergency Contact Name:_____ Phone:_____ Relationship:_____

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand that all charges, co-payments, and deductibles determined to be patient responsibility will be charged to the patient. I authorize payment of insurance benefits directly to The William Storms Allergy Clinic.

As a present or future member of a Health Maintenance Organization (HMO) or other third party payor, I recognize that I may be required by my insurance to get Primary Care Physician's (PCP) referral prior to being treated. If I do not obtain a referral I understand that I am circumventing my health care plan and may be required to pay for services rendered. In such cases, I agree to accept full financial responsibility for charges related to the services rendered without a referral.

❑ I am interested in clinical research studies. I authorize Storms Clinical Research Institute to contact me at:_____
Phone Number

Signature:_____ Relationship to patient ❑Self ❑Parent ❑Guardian Date: _____

HIPAA ACKNOWLEDGEMENT

I have been given and have read the HIPPA informational sheet. I consent to allow The William Storms Allergy Clinic to use or disclose personal health information about me for the purpose of treatment, payment and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as described on the informational sheet.

_____ _____

Patient Signature ***Date*** ***(Signature of parent/guardian)*** *If patient is a minor child* ***Date***

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The practice may use or disclose your protected health information only with your written authorization. You may revoke, in writing, authorization at any time. If you choose to restore this authorization, it must be done in writing, on a new form.

I authorize The William Storms Allergy Clinic, to discuss my protected health information with _____*;*
(Printed name of authorized individual)

_____*;* _____*;* _____*;* _____*;* _____
(Address) *(City)* *(State)* *(Zip)* *(Relationship to patient)*

<u>This authorization is good until revoked</u>

_____ _____
(Signature of patient authorizing disclosure) *(Signature of staff member; witness to disclosure authorization)*

All of the information on both the front and back of this form is current and correct.
(Please initial and date on the lines provided below)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____