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)

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________