United Doctors

PATIENT REGISTRATION FORM

PATIENT INFORM		
Today's Date:	**Social Security Number:**	**Date of Birth:**
Last Name: **First:** **Middle:**		**Gender at Birth:** ❑ Male ❑Female ❑Unknown
Street Address:		**Cellular Phone Number:** ( )
City: **State:** **Zip Code:**		**Other Phone Number:** ( )
E-Mail Address:	**If Under 18, Parent/Guardian's Name:**	
Sexual Orientation: ❑ Lesbian/ Gay ❑ Heterosexual (or straight) ❑ Bisexual ❑ Something else ❑ Don't know ❑Choose not to disclose	**Gender Identity:** ❑ Female ❑ Male ❑ Transgender (Female-to-Male) ❑ Transgender (Male-to-Female) ❑ Other ❑ Choose not to disclose	
How Did You Hear About The Health Center? ❑ Family ❑ Friend ❑ Flyer ❑ Center Staff ❑ Internet ❑ Hospital ❑ Other: _____		

EMERGENCY CONTACT [IN CASE OF EMERGENCY, PERSON WE MAY CONTACT]

FIRST AND LAST NAME:_____ **PHONE NUMBER:**_____

RELATIONSHIP TO PATIENT: ❑ Spouse ❑ Child ❑ Parent ❑ Other: _____

I grant the above person permission(s) to: ❑ share medical information ❑ make medical decisions ❑ renew medications ❑ discuss my billing account

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑ Prefer not to Report

Race: ❑ Black ❑ White ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ More than one race ❑ Prefer not to Report

Marital Status? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Employed? ❑ Yes ❑ No	**Name of Employer:**

INSURANCE INFORMATION (PLEASE ANSWER WITH POLICY HOLDER INFORMATION)

PRIMARY INSURNACE INFORMATION		**SECONDARY INSURNACE INFORMATION**	
Policy Holder's Name:		**Policy Holder's Name:**	
Relationship to Policy Holder:		**Relationship to Policy Holder:**	
Date of Birth:	**Social Security:**	**Date of Birth:**	**Social Security:**
Insurance Name:	**Phone:**	**Insurance Name:**	**Phone:**
Policy #:	**Group #:**	**Policy #:**	**Group #:**

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MEDICAL HISTORY

Patient Name _____ Date fo Birth_____

MEDICATIONS - *Please List all Medications you are currently taking:*

Medication	Dosage	How is Taken	Frequency

ALLERGIES - *Please List all Allergies:*

Allergies	Allergies	Allergies

PAST MEDICAL HISTORY - *Do you now or have you ever had:*

☐ Diabetes	☐ Heart Disease	☐ Anemia
☐ High Blood Pressure	☐ Kidney Disease	☐ Hepatitis
☐ High Cholesterol	☐ Pulmonary Embolism	☐ HIV/AIDS
☐ Hypothyroidism	☐ Asthma	☐ Epilepsy (seizures)
☐ Goiter	☐ Emphysema (COPD)	☐ Hepatitis
☐ Cancer (type) _____	☐ Stroke	☐ Stomach or Peptic Ulcer

SURGICAL HISTORY - *Please list any surgeries you have had including the year and month:*

Surgeries	Month	Year	Frequency

FAMILY HISTORY - *Please list your Family History:*

	If Living Age (s)	If Living Health & Psychiatric	If Deceased Age(s) at Death	If Deceased Cause
Father				
Mother				
Siblings				
Children				

SOCIAL HISTORY - *Do you use*

Tobacco ☐ YES ☐ NO	Alcohol ☐ YES ☐ NO	Recreational Drugs ☐ YES ☐ NO
Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Occupation:	

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PATIENT CONSENT FOR TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize the Center Providers and their staff to conduct any diagnostic examinations, tests and procedures, as well as provide any medications, treatment or therapy necessary to effectively assess and maintain my health, to assess, diagnose and treat my illness or injuries.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care Providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Telemedicine and AI Scribe Consent

☐ I consent to receive healthcare services through telemedicine, including audio and/or video communication. I understand that telemedicine has potential limitations, including technical difficulties or interruptions, and that I may request an in-person visit when appropriate. I may withdraw my consent at any time without affecting my care.

☐ I consent to the use of AI Scribe during my visit to assist my healthcare provider with documenting my medical history and clinical notes. I understand that the technology may process audio from my visit to generate documentation, which will be reviewed by my healthcare provider. I understand that I may decline the use of this technology without affecting my care.

Signature: _____

Patient/Parent/Legal Guardian Signature Date

PERMISSION TO RELEASE & EXCHANGE INFORMATION

The Center creates and receives confidential records regarding your health while under our care. The Center will not release your confidential records to any individual or organization (including family members), without your express, written permission. This policy includes written consent for us to refer you to a specialist outside of our Center.

❑ I consent to the release and exchange of confidential records to family members, organizations and referral sources requesting it.

❑ I consent for the Provider to obtain my prescription history from external sources.

❑ I consent to the release of confidential records, medical results or medications to the named individuals and organizations listed as follows: _____

❑ I consent for an employee to discuss my billing account with my spouse, family member, or significant other. If allow, only those listed here: _____

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Patient Portal:
The Patient Portal allows for patients to review existing appointments, lab results, medications, request prescription refills, medical history, patient statements and send secure messages to Center staff. To enroll in this internet-based option, please click the box below. The email address provided on the Patient Enrollment Form will be used as your log-in.

❑ Enroll me

Signature: _____

Patient/Parent/Legal Guardian Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at time of service. Payment may be made by cash or major credit card. Any fees, deductibles, co-insurance, or co-payment is payable at time of service.

PAYMENT RESPONSIBILITY: The undersigned assumes responsibility for payment for services in accordance with the standard rates and terms of the Center, whether to sign as a patient or guarantor, **where insured or uninsured**. As the undersigned, I fully understand: (a) my insurance, if any, is a contract between myself and the insurance company, except in certain cases where the Center has a specific contract with my PPO, HMO, or other third party payer; the Center does not explain nor determine if services are covered by my insurance, if any, so any inquiries to explain or determine insurance coverage for services are between myself and the insurance company; (b) any balance remaining after insurance, if any, approves or denies payment is my responsibility to pay; if my insurance company denies a claim for services for any reason, whether at the time or subsequent to receiving services, I assume full responsibility for payment in accordance with the standard rates and terms of the Center; (c) if I am not able to pay the standard rates for services received financial arrangements can be made for anyone facing hardship.

In the event all charges for services are not paid in full when due, whether insured or uninsured, and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for balance of charges for services and treatment received and all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, and court costs.

I hereby authorize the Center to release all medical information to all my insurance carriers, other third party payers, including Medicare or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Worker's Compensation or other insurance purposes.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize the payment of any insurance or other medical benefits directly to United Doctors. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

Signature: _____

Patient/Parent/Legal Guardian Signature Date

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CENTER POLICIES

Patients can find the full text of Policies listed below on the "United Doctors Website

Referrals
Referrals must be requested at least three working days before the date the referral is needed. Referrals will only be given if the doctor feels a specialist attention is needed. You must see the doctor before he/she will refer you to a specialist unless the physician decides otherwise.

Prescription Refills
We do not process refill requests after hours, holidays or on weekends unless it is an emergency. It is patients responsibility to make an appointment to get refills when refills are necessary. If you have not seen the doctor within three months period, you will require a visit before any refills. We do not provide refills for controlled medication without a visit.

Test Results
If your test results show something unusual, we will contact you to schedule an appointment to discuss the results. Should you like to discuss your test results, please schedule an appointment with the doctor. Abnormal test results will not be given over the phone. Please be aware that test results can take anywhere from two days to two weeks to reach our office.

Payments
All co-payments, deductibles and non-covered services are due at the time of service. There is a $25.00 fine for all returned checks. Please make every effort to pay your bill in a timely manner. Financial arrangements can be made for anyone facing a hardship.

Appointments
We request that you notify our office if you are unable too keep your appointment. A 24 hour notice is required to cancel the appointment. A fee of $25 will be charged for all of no show appointments and cancellation less than 24 hours.

Medical Records
We require seven days notice for all medical records. There is a charge of fifty cents per page for copying records.

Health Forms
Blank forms will not be accepted. We only accept forms that have patient name and medical history portion filled out. Form completion is usually 3-5 business days. There is a fee of $20 per form.

I have read and I understand all of the above office policies.

Signature: _____

Patient/Parent/Legal Guardian Signature Date