FHC Patient Registration UPDATE INFORMATION

**Patient Name:**_____
Last First M

Date of Birth:_____ Sex: M/F SS#: _____-_____-_____

Mailing Address: _____City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____

Email Address:_____

Marital Status: Single / Married / Divorced / Separated / Widowed

Guarator Information (Person Responsible for Paying Bill)

Name:_____ Relation to Patient:_____
Last First M

Date of Birth:_____ Sex: M/F SS#: _____-_____-_____

Mailing Address: _____City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____

Email Address:_____

Health Insurance Carrier :_____

ID #_____ Group Number (If Applicable):_____

**Patient Release for Non-Compliance with Medical Orders**

The undersigned hereby release all physicians of Family Healthcare from liability for all complications due to the patient's non-compliance with the regimen of treatment as suggested by the medical staff:

Initial: _____

**Assignment of Benefits / Release of Information**

I authorize payment of medical benefits to Family Healthcare. I authorize the release of any medical information necessary to process this claim or any future claims. I understand that I am financially responsible for all charges whether covered or not covered by health insurance:

Initial: _____

I acknowledge that I have been presented with a copy of Family Healthcare Notice of Privacy Practices

Initial: _____

I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of care/services as it is established. In the course of my medical treatment I can expect to be evaluated by a nurse, mid-level practitioner and/or physician. I understand that my prescription history will be obtained from external sources.

Initial: _____

I understand that under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to Conduct, plan and direct my treatment and follow up to multiple health care providers who may be directly/indirectly involved in my treatment. *Obtain payment from third party payers. *Conduct normal health care operations such as quality assessments and physician certifications. I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment of health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I hereby authorize my private health information to be released to the following individuals:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

I understand that certain laboratory and imaging studies will have to be sent out to a reference facility, i.e. Quest, Clinical Pathology Laboratories, or Radiology Associates. These facilities will send a separate bill for those studies. I understand that Family Healthcare charges a technical fee for equipment, technicians, and other operating expenses. I understand I will be receiving a separate bill from the reference facilities for any lab or imaging work sent to them.

Initial: _____

Prescription Refill Policies

- If you are prescribed medications, you will be provided with an initial prescription and refills to last until the suggested follow-up visit. It is your responsibility to schedule your follow-up appointment before the prescription runs out to insure a continued supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To give good clinical care patients must be seen on a regular basis.
- Only minor changes in your medication regimen can be made between appointments. If a major change in your medication regimen is needed you will need to be seen by your provider before these changes can be made.
- We do not accept faxed refill requests from your pharmacist.
- It may take up to 48 hours for reviewing your medical history and deciding if the requested refill is appropriate.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescription refills will not be provided on the weekends.
- All medications are to be taken as prescribed. If patient takes medication in excess of what is prescribed and runs out of medication early (prior to refill date), the refill will not be authorized until refill date.
- In general, if a patient is already being treated by a pain management physician, all pain medications will need to be managed by the patient's existing pain management specialist.
- We require regular blood work for all patients on prescription medication, which is necessary for monitoring the safety and effectiveness of the medication. The interval will vary based on the medication prescribed. Patients who do not schedule their regular intervals of blood work will not have their prescriptions refilled.

Initial: _____

**Family Healthcare provides electronic prescriptions (E-Prescribing) to pharmacies through SureScripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need or a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone, and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. By signing below, you are indicating you understand the above listed refill policies and authorize Family Healthcare to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medical dispense history as long as you are a patient at this office or until you withdraw that consent.**

**Initial: _____**

**Signature:_____ Date:_____**

**Relation to Patient: Self / Parent / Guardian**