SOUTHERN CLINIC, P.C.

Registration Form

Date: _____

Please print legibly.

Patient's Name:			Date of Birth:	Age:	Sex:
Address:			City:	State:	Zip:
Home Phone #:	Work Phone #:	Cell Phone #:	Email Address:		
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Other	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Primary Language: ☐ English ☐ Spanish ☐ Other	Primary Phone #: ☐ Home ☐ Work ☐ Cell	
SSN#:	Referred By:				
Emergency Contact:	Phone #:	Relationship:			
Patient Employer:			Phone #:		
Spouse's Employer:			Phone #:		
Primary Insurance:			Insurance #:		
Secondary Insurance:			Insurance #:		
Preferred Pharmacy:	Preferred Communication Method: Phone Call: ☐ Home ☐ Work ☐ Cell Other: ☐ Email ☐ Text Message				

I certify that this information is true and complete to the best of my knowledge.

_____ _____ _____

Patient's Signature | Preparer's Signature | Date

SOUTHERN CLINIC, P.C.

HIPAA Patient Disclosure Form for Health Information

Patient Name: _____

Patient Date of Birth: _____ Chart#: _____

The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:

1. Created or received by a health care provider, health plan, employer or healthcare clearing house.
2. Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
3. The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

1. For treatment, payment or health care operations as permitted under law.
2. Uses or disclosure to a personal representative assigned by patient.
3. Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
4. For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

I _____am a patient of Southern Clinic, P.C. and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons and agencies or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility. I HAVE READ THE PERMITTED DISCLOSURE FORM AND I UNDERSTAND IT.

_____ _____

Patient Signature Date

I do hereby assign the following persons as trustees of my personal health information and I acknowledge that they may have access my medical information at any time:

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

SOUTHERN CLINIC, P.C.

Medical Insurance Waiver

PLEASE READ BEFORE SIGNING

Dear Patient:

Congress has passed certain policies that were established by Medicare or your health insurance carrier. Therefore some of the medical procedures and tests which I deem advisable or necessary in diagnosing and treating you may have been declared as not medically necessary by Medicare and/or your health carrier.

If such a declaration is made, you will be expected to pay for such services in full. Also, if you do not currently have medical insurance, you will also be expected to pay in full for all services rendered. In my diagnosis and treatment of your health problems, I may feel it is in your best interest to order certain tests, medical treatment, labs, x-rays, etc. which may be declared as not covered, thus leaving you with a responsibility for payment. However, I will only do this if I feel that it is medically necessary.

In ordering such treatments or tests, let me assure you that I will only order such tests that I feel are necessary for your treatment, care and well-being.

If you have questions about whether a particular test or service is covered or how much a particular procedure costs, please request to discuss it with a member of my insurance staff or with myself prior to receiving any treatment. We will be happy to discuss this with you.

Sincerely,
The Physicians and Mid-Level Providers of Southern Clinic, P.C.

I have carefully read the above statement or had someone read it to me and understand that I am to pay for services not covered by Medicare or other health care providers or agencies. It is my duty to notify my providers' office of any change affecting my insurance coverage or to pursue payment by my insurer should they fail to pay a covered charge. In the event I fail to pay for services or expenses related to my treatment by my provider, I personally agree to pay all reasonable costs of collections including a reasonable attorney's fee. This agreement is deemed continuing in nature and will apply to all services and dates of treatment by my provider. In consideration of receiving treatment by my provider, I hereby waive my right to claim exemptions allowed under Alabama law. I also agree to operate in accordance with any and all office policies of my provider in regard to paying for services, etc. I understand that unpaid balances can accrue interest at a rate of 1.5% per month according to Alabama law.

_____ _____

Signature Date

_____ _____

Witness' Signature Date

SOUTHERN CLINIC, P.C.

E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

→ **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.

→ **Medication history transactions –** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that **Southern Clinic, P.C.** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed) _____ Date of Birth ___ /___ /_____

Signature of patient (or representative) _____

Date ____ /____ /_____ Relationship if other than patient _____

Consent Denied _____ Date ____ /____ /_____