Premier Care
INTERNAL MEDICINE

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

First	MI	LAST
Street Address:		
City	State	Zip
Home Telephone #		Preferred Y N
Cell Phone #		Preferred Y N
Birth Date:		
Sex MALE FEMALE		Marital Status
Ethnicity (Circle One): White African American Asian American Indian or Alaska Native Pacific Islander		
Patient Email Address		
Emergency Contact Name		Relationship to Patient
Emergency Contact Cell Phone #		
Employer Name		
Work Telephone #		
May we leave a message for you at work?		

PRIMARY INSURANCE INFORMATION

Primary Insurance Name		
Claim Address		
City	State	Zip
Group Number		
Policy (ID) Number		
Subscriber Name		Relationship to Patient
Subscriber Date of Birth		
CoPay Amount ($)		

SECONDARY INSURANCE

Secondary Insurance Name		
Claim Address		
City	State	Zip
Group Number		
Policy (ID) Number		

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RESPONSIBLE PARTY INFORMATION

First	MI	Last
Street Address		
City	State	Zip
Home Telephone #		
Relationship to Patient		
Account Email Address		

Subscriber Name	Relationship to Patient
Subscriber Date of Birth	
Subscriber Employer	
Subscriber Employer Phone #	

(Please attach hand written sheet for any additional insurance information)

How were you referred to our practice (Insurance, friend / family, internet, advertisement, doctor referral, etc.)?

PHARMACY INFORMATION

Pharmacy Name		
Pharmacy Address		
Pharmacy City	State	Zip
Pharmacy Telephone #		

I verify that the above information is true to the best of my knowledge.

I also agree to allow PREMIER CARE INTERNAL MEDICINE, PA and its Staff to obtain and / or share my medical information to/with all concerned individuals and / or organizations (including Pharmacies) as required, within the extent allowable and described in the HIPPA Notice of Privacy Practices, for the purpose of providing the patient, appropriate medical care and conducting all transactions related to the medical care, including financial and business transactions.

_____ _____

(Signature of Patient / Legal Guardian) **Date**

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Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Premier Care Internal Medicine, PA appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Premier Care Internal Medicine, PA, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Premier Care Internal Medicine, PA, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ **Date** _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Premier Care Internal Medicine, PA, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Premier Care Internal Medicine, PA, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ **Date** _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Premier Care Internal Medicine, PA will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ **Date** _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Premier Care Internal Medicine, PA. I agree to pay Premier Care Internal Medicine, PA, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ **Date** _____

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MEDICAL INFORMATION RELEASE CONSENT FORM

Patient Name:

Patient DOB:

I, _____ give _____
(Patient name) **(name of Parent, Spouse, etc.)**

and / or _____

permission to inquire and receive information contained in my medical record at Premier Care Internal Medicine, PA. In addition, the above-named person may inquire and receive information from the staff at Premier Care Internal Medicine, PA regarding my presence in the office, any test results, any testing or physician visits ordered by my primary care physician, and/or dates of treatment.

Premier Care Internal Medicine, PA will give the information only to the person(s) named above (apart from medical use by physician and clinical staff) and will not be held liable for doing so.

You may also leave me a voice-mail per the following selection:

_____My Home: _____

_____My Cell: _____

_____My Work: _____

Please leave a: _____ Detailed Message

_____ Message Only asking me to return your call

This authorization remains valid unless revoked by me in writing.

Patient Signature:

Witness:

Date:

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ACKNOWLEDGEMENT of receipt of HIPPA Notice of Privacy Practices

I / We acknowledge that we have received, read and understood the **HIPPA Notice of Privacy Practices** from **PREMIER CARE INTERNAL MEDICINE, PA**.

_____

(Patient or Parent / Guardian Signature)

_____ _____

(Patient or Parent / Guardian Name) **(Date)**

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ACKNOWLEDGEMENT of receipt of New Patient Policies Package

I / We have received, read and understood the **New Patient Policies Package** from **PREMIER CARE INTERNAL MEDICINE, PA**.

_____

(PATIENT OR PARENT/GUARDIAN SIGNATURE)

_____ _____

(PATIENT OR PARENT/GUARDIAN NAME) **(DATE)**

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Release of Medical Records

Patient Name: _____D.O.B._____
Telephone number: _____

1. I authorize _____ to, disclose or release the following protected health information about the above named patient: (includes dates below)
    - Progress notes including history and physical
    - Laboratory results, x-ray imaging reports (Mammogram, CT, MRI, etc.)
    - Entire Medical record
    - Other(specify what is to be released): _____

    Treatment From (date) _____ to (date) _____

2. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment or testing for alcohol or drug abuse.

3. I authorize the disclosure of the listed information to send to the following individual or organization:
   Name: **PREMIERCARE INTERNAL MEDICINE, PA - DR. PURVI SANGHVI**
   Address: **3701 Eldorado Pkwy, Suite D, McKinney, TX 75070**
   Phone: **972-808-7111**; Fax: **972-548-7112**
   For the purpose of: _____

4. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the office. I understand that the cancellation will not apply to the information that has already been released under this authorization. I understand that this cancellation will not apply to my insurance company when law gives my insurer the right to consent a claim under my policy number.

5. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date appearing at the bottom.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain medical treatment. However, information will not be released to the above indicated individual or organization without my signature.

Signature of patient or legal representative: _____; Date:_____

If signed by legal representative, relationship to patient:_____