REGISTRATION FORM

(Please Print)

Pharmacy Name/Number:	PCP:

PATIENT INFORMATION

Patient's Last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:			Apt. #	Social Security no.:		
Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )	Email address			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Other	Languages Spoken :					
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )			
Is this person a patient here? ❑ Yes ❑ No						
Employer:	Employer address:	Employer phone no.: ( )				
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance	❑ Medicare	❑ BCBS	❑ Aetna	❑ UHC	❑ Cigna	❑ Lifewise
❑ HealthNet	❑ Arizona Foundation	❑ Great West	❑ Pacificare PPO	❑ Secure Horizons	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize 4C Medical Group or insurance company to release any information required to process my claims.

Signature: Date:

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire will become part of your medical record.

Name: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Infectious illness: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Polio ☐Valley Fever ☐Mono. ☐ TB ☐ HIV ☐Other:

Immunizations and dates:				
	☐ Hepatitis	☐ Shingles	☐ Pneumonia	☐ MMR *Measles, Mumps, Rubella*
	☐ Tetanus	☐ Pertussis	☐ Influenza	☐ Other

Please check any medical problems you have had in the past:

☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial fibrillation ☐ Autoimmune disease ☐ Blood transfusion ☐ Cancer, type: _____ ☐ Cataracts ☐ Chronic lung disease or COPD ☐ Chronic pain ☐ Colon polyps ☐ Congestive heart failure ☐ Deep vein thrombosis/ Blood Clots ☐ Dementia	☐ Depression ☐ Diabetes mellitus ☐ Skin disorder; Type: _____ ☐ Fibromyalgia ☐ GERD (heartburn) ☐ GI bleed ☐ Glaucoma ☐ Heart attack ☐ Heart disease or pacemaker ☐ High cholesterol ☐ High blood pressure ☐ Inflammatory bowel disease ☐ Irritable bowel syndrome ☐ Insomnia ☐ Kidney disease	☐ Kidney stones ☐ Liver disease ☐ Migraine headaches ☐ Neuropathy ☐ Osteoporosis/Osteopenia ☐ Parkinson's disease ☐ Pulmonary embolism ☐ Rheumatic fever ☐ Seasonal allergies ☐ Shingles ☐ Sleep apnea ☐ Stroke or TIA ☐ Thyroid disease ☐ Ulcers, Type: _____ ☐ Other (specify) _____ _____

Please check any surgeries you have had:

☐ Appendectomy ☐ Bariatric surgery ☐ Breast surgery ☐ Colonoscopy ☐ Cosmetic surgery ☐ C-section	☐ Eye surgery; Type: _____ ☐ Gall bladder removal ☐ Heart surgery, type:_____ ☐ Hernia repair, type: _____ ☐ Hysterectomy ☐ Orthopedic surgery, type:_____ _____	☐ Pacemaker ☐ Spine Surgery; Type: _____ ☐ Tubal Ligation ☐ Vasectomy ☐ Other (specify): _____ _____ _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

NAME:	DOB:	DATE:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name the Drug	Dose/Type	Frequency/Method Taken
Aspirin		Daily? ☐ Yes ☐ No
Opioids		Chronic? ☐ Yes ☐ No
Medical Marijuana		
Contraception		

Allergies to medications:	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY					
Caffeine	☐ None	☐ Coffee ☐ Tea ☐ Other How much? _____			
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
	Have you ever felt you needed to cut down on your drinking?			☐ Yes	☐ No
	Have people annoyed you by criticizing your drinking?			☐ Yes	☐ No
	Have you ever felt guilty about drinking?			☐ Yes	☐ No
	Have you ever felt you needed a drink first thing in the morning to steady your nerves?			☐ Yes	☐ No
Tobacco	Do you use tobacco or nicotine products? ☐ # of years			☐ Yes	☐ No
	☐ Cigarettes – #/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
Gynecological History	# of pregnancies:_____ # of live births: _____ Menopause ☐ Yes ☐ No				

Printed name Signature (patient or guardian) Date

FINANCIAL POLICY

Thank you for choosing 4C Medical Group PLC as your health care provider. We are committed to providing quality medical care. In an effort to avoid confusion and misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

Insurance – all patients
Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. 4C Medical Group PLC does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

Non-insured patients
If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We will, as a convenience to you, provide a prepared claim form to allow the patient to submit for reimbursement if desired. We offer a competitive cash fee schedule for our patients with no insurance.

Deductibles/Co-pays
Our insurance contracts require us to collect deductibles and co-pays at the time of service.

Appointments
We strive to provide the best possible service and availability to all of our patients. Our policy is to charge for missed appointments unless cancelled at least 24 hours in advance. Our no-show/late cancellation charge is $25. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

Paperwork Services
Any paperwork filled out by our providers such as Short-term disability, or FMLA are subject to a $25 charge.

Medical Record Copies
Copies of medical records for personal use or for parties other that your insurance company or other physicians involved with your care are subject to a $25 charge.

Returned Checks
All checks returned from the bank for non-payment are subject to a $25 charge.

Collection Agency
Any account turned over to a collection agency is subject to a fee amounting to 30% of the total amount turned over.

This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

_____ _____
Patient Name **Date**

Assignment of Benefits:
I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO 4C MEDICAL GROUP FOR ANY SERVICES FURNISHED ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES, FORMERLY KNOWN AS HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

_____ _____
Patient Name **Date**

Acknowledgment of Privacy Practices and Permission to Leave Messages

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and/or reviewed a copy of 4C Medical Group Notice of Privacy Practices

I give permission to communicate messages in the following manner:

_____ You may leave a message on my answering machine located at this number _____

_____ You may leave a message on my cell phone _____

_____ You may leave a message with my spouse, _____ at this number _____

_____ You may leave a message with another person, _____ at this number _____

I give permission to communicate messages about the following:

_____ Labs, x-rays, and other test results

_____ Prescriptions

_____ Billing or insurance matters

_____ _____

Patient Name **Date**

Authorization for the Release of Patient Information

FROM: Provider/ Facility: _____

Address: _____

City, State Zip: _____

Phone/ Fax #: Phone: _____Fax: _____

RE: Patient Name: _____

DOB: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

❒ **Complete medical record, meaning every page in my record**
❒ **Office notes, consult notes, operative reports, and hospital records**
❒ **Labs, including but not limited to, blood chemistry, pathology, and histology**
❒ **X-rays and other imaging reports**
❒ **Pharmacy and prescription records**
❒ **Billing records**

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of: _____

You are authorized to release the above records to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

I understand the following:

That I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization; that the information released in response to this authorization may be re-disclosed to other parties; and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Patient Signature or Legal Representative **Date**