ASSOCIATES IN PRIMARY CARE

REGISTRATION FORM

(Please Print)

The nation is entering a new era of health care where patients and doctors can use electronic health records to improve health and the way health care is delivered in this country. The federal government is mandating that we enter certain information into our electronic health records. Please fill out this registration form and please do not hesitate to ask questions.

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.

Birth date: / /	Age:	Sex: ☐ M ☐ F	Preferred Language: (i.e.: English)

Ethnicity:

☐ Hispanic/Latino
☐ Not Hispanic/Latino

Race:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Marital status

☐ Single ☐ Married
☐ Divorced ☐ Separated
☐ Civil Union ☐ Domestic Partnership
☐ Widowed

Street address:	Apt#:	E-mail:

City:	State:	ZIP Code:	Driver's License no.:

Occupation:	Employer:	Employer phone no.:
		( )

To respect your privacy please tell us which of the following numbers we should call to communicate with you regarding appointments, lab results, referrals, etc. Only list the phone numbers you want us to call and/or leave messages. You must list at least one contact number.

PRIMARY METHOD OF CONTACT ( ) HOME , ( ) WORK OR ( ) CELL

Home:	Work:	Cell:
( )	( )	( )

IN CASE OF EMERGENCY/OTHER CONTACT(S)

I allow APC to disclose protected health information about me such as: Lab Results, Test Results (i.e. MRI, CT Scan, U/S, X-Ray, etc), Medication Information, Medical Records, and appointments to the following individual(s): (I understand that I can change this/these individual(s) at any time)

Name of local friend, relative, loved one:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )
Name of local friend, relative, loved one:	**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**
		( )	( )

AUTHORIZATION OF SERVICES

		YES	NO
I allow APC to contact me with automated appointment reminders via:	E-Mail:	☐	☐
	Mobile:	☐	☐
I allow APC to obtain information on my complete drug history as reported to the DEA for the purposes of electronic prescribing and record keeping.		☐	☐
I allow APC to upload my immunization history to the New Jersey state registry for reporting and record-keeping purposes.		☐	☐

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Subscriber's name if other than patient:	Patient's relationship to subscriber: ☐ Spouse ☐ Child ☐ Other:

OVER PLEASE ----------→

ASSOCIATES IN PRIMARY CARE

Office Policy/Signature

We have found that good communication with our patients regarding our office policy assists us with providing a good physician-patient relationship.

1. Patients who are unable to present an ID card may be required to pay for services rendered at the time of the visit or to reschedule thereafter.
2. It is your responsibility to present your current insurance card at the time of service. If the current information is not on file, you will be responsible for any/all charges. If the wrong insurance information is presented at the time of your visit no resubmission will occur.
3. Please be advised that it is your responsibility to understand your insurance benefit plan.
4. Insurance co-payments are collected at the time of check-in.
5. Reschedule or cancellation of an appointment without 24-hour prior notice will be subjected to a $50 charge.
6. If you are unable to pick up referrals, lab results, prescriptions, or any other medical information you can request another individual pick these items up, however written authorization is needed and they will need to present us with a valid form of I.D. (i.e. driver's license).
7. If an insurance requires a Primary Care Physician but none of our doctors at APC are chosen, full payment is rendered at the time of service. If an open access plan does not have one of our providers selected as your PCP, the specialist copay is due at the time of the visit.
8. If we do not participate with your insurance full payment is rendered at the time of service. Out of Network benefits may pay a portion of the bill or if there is no Out of Network benefits you will be responsible for all charges incurred.
9. Patient balances are billed immediately upon receipt of your insurance carrier's explanation of benefits and due within ten business days.
10. We accept payments by cash, check, VISA or Master Card. There is a $30 bank service charge for any returned check or stop payment. If paying by check, we require a driver's license number.
11. If special payment arrangements are needed, please alert our billing manager as soon as possible.
12. Any account outstanding over 90 days that has not made arrangements with our billing manager will be turned over to a collection agency. Upon turnover to the collection agency, you will be discharged from the practice.
13. If the account is sent to collections, I hereby agree and promise to pay a collection fee of 50% of the total balance due on the account.
14. I understand and consent to be contacted by you or your agents and vendors by telephone, automated dialing systems, pre-recorded/artificial voice message, text message, e-mail, mobile application, and US mail. I understand telephone/text charges may apply. This consent includes any postal address, email address or phone number, including cell phone number, that I have given you or that I give to you in the future. I understand I may opt-out of receiving text messages by notifying you in writing (including by responding via text message).
15. You agree, you may be contacted via pre-recorded/artificial voice messages and/or use of an automated dialing device for any and all confirmation of appointments and/or non-critical lab results.
16. I have been informed, unused medications that remain in your medicine cabinet are susceptible to theft and misuse. To prevent medications from getting into the wrong hands, New Jersey's Office of the Attorney General and Division of Consumer Affairs urge you to properly dispose of your expired and unwanted prescription medicine at a nearby Project Medicine Drop location. DROP OFF IS SIMPLE, ANONYMOUS AND AVAILABLE 24 HOURS A DAY – 365 DAYS A YEAR, NO QUESTIONS ASKED. Simply bring in your medications and discard them in an environmentally safe manner. Always scratch out the identifying information on any medicine container you are discarding. For a list of locations, please visit www.NJConsumerAffairs.gov/meddrop.

If you have any questions regarding our office policy, please do not hesitate to ask a member of our staff.

I hereby give my consent for APC to use/and or disclose protected health information about me to carry out treatment, payment, an health care operations. I authorize the release of medical information necessary to process claim forms and the payment of medic benefits to APC for medical services rendered. A copy of this authorization shall be valid as the original. I also authorize my insuranc benefits be paid directly to the physician. I understand that payment for immunizations and procedures will depend on my insuranc benefits, rather than on medical necessity. I understand that insurance companies may deny payment for tests done too frequently or n deemed medically necessary for my condition. If any tests, immunizations, procedures, routine screenings, and/or physicals are denied t my insurance company, I will be responsible for payment.

If I have Medicare, I authorize any holder of my medical or other information to release to the Social Security Administration and Healt Care Administration or its intermediaries any information needed for this or any other related Medicare Claim. I permit a copy of th authorization to be used in place of the original. I request payment of medical insurance benefits either to myself or the party who accep assignment. All regulations pertaining to Medicare assignment of benefits apply.

I have read and understand the office policy and agree to abide by the policy. I acknowledge that I have been provided with the Notice Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. APC reserves the right to revise i Notice of Privacy Practices at any time.

Patient/Guardian Signature: **Date:**