

New Patient Registration | Updated Contact Information

<b>Patient Information:</b>	<b>Legal Name:</b>	<b>Preferred Name:</b>	<b>Date:</b>
	<b>Street Address:</b>		
	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
	<b>Date of Birth:</b>	<b>Age:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
	<b>Primary Phone Number:</b> <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<b>Secondary Phone Number:</b> <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
	<b>Email:</b>	<b>Social Security Number:</b>	
	<b>Emergency Contact:</b>	<b>Emergency Contact Phone Number:</b>	
	<b>Emergency Contact Relation:</b>	<b>May we discuss medical information with this contact?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Preferred Pharmacy Name:</b>	<b>Location/Intersection:</b>	
	<b>Which category best describes your race?</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hawaiian or other Pacific Islander <input type="checkbox"/> Asian (includes Pakistan or Indian origins) <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____ <b>Do you consider yourself Hispanic/Latino?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline <b>What is your primary language?</b> _____		
<b>How did you hear about Questcare Medical Clinic? (check all that apply)</b> <input type="checkbox"/> Established Patient <input type="checkbox"/> Drive By <input type="checkbox"/> Internet <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Facebook <input type="checkbox"/> ZocDoc <input type="checkbox"/> Advertisement <input type="checkbox"/> ER/Hospital/Urgent Care: _____ <input type="checkbox"/> Insurance Company <input type="checkbox"/> Mail <input type="checkbox"/> My Doctor: _____ <input type="checkbox"/> Other: _____			

Complete this section if guarantor is someone other than the patient or a minor.

<b>Responsible Party:</b>	<b>Name:</b>	<b>Relationship to Patient:</b>		
	<b>Mailing Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
	<b>Primary Phone Number:</b>	<b>Secondary Phone Number:</b>		
	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth:</b>	<b>Social Security Number:</b>	

<b>Insurance &amp; Subscriber Information:</b>	<b>Primary Insurance Company:</b>	<b>Policy ID:</b>	<b>Group #:</b>
	<b>Subscriber Name:</b>	<b>Relationship to Patient:</b>	
	<b>Subscriber Date of Birth:</b>	<b>Subscriber SSN:</b>	
	<b>Secondary Insurance Company:</b>	<b>Policy ID:</b>	<b>Group #:</b>
	<b>Subscriber Name:</b>	<b>Relationship to Patient:</b>	
	<b>Subscriber Date of Birth:</b>	<b>Subscriber SSN:</b>	

Approved HIPAA Contacts:

My preferred methods of communication regarding my **medical condition(s)** is indicated below (**check one**):

- Home Phone     Work Phone     Cell Phone     SMS/Text Message     Mailed Letter     Guardian
- Secure Email     Patient Portal

Preferred Time to Call:     Morning     Afternoon     Evening

If the above method of communication is by phone, please check the appropriate box below (**check one**):

- Leave a message with detailed information.     Leave a message with a call-back number only.

*Please note that you are responsible for any charged incurred in receiving our communications. Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be contacted at all.*

Preferred Method of Communication:

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **BILLING ACCOUNT** and **MEDICAL CONDITION(S)** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that Questcare Medical Clinic is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.

\_\_\_\_\_ Relationship to Patient Phone Number

- Billing Account Information     Medical Condition Information

\_\_\_\_\_ Relationship to Patient Phone Number

- Billing Account Information     Medical Condition Information

Prescription Order Pick-up:

There may be times when you need a friend or family member to pick-up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the prescription, your designee will need to present valid picture identification and sign for the prescription.

\_\_\_\_\_ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list any specialists/doctors or other medical health providers that care for you.**

(examples: cardiologist, physical therapy)

Circle of Care:

Name:	Specialty:	City:

Adv. Dir:

**Please list any Advance Directives and supply office with copies for patient's file:**

\_\_\_ Medical Power of Attorney    \_\_\_ Hospice    \_\_\_ Do Not Resuscitate    \_\_\_ Out of Hospital DNR

Signature of Patient, Parent, or Legal Guardian

Date

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Patient Name

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DOB

\_\_\_\_\_ **Consent for Treatment and Payment Agreement:** I consent to Questcare Medical Clinic's administration and performance of general treatment, use of prescribed medications, performance of diagnostic procedures, tests and cultures, and performance of other laboratory tests that my physician or his designee determines medically necessary or advisable based on the judgment of my physician or their assigned designees. I give this consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. I understand that my consent on this form extends to practice locations affiliated with Questcare Medical Clinic. A photocopy of this consent shall be as valid as the original. I understand that while my consent is voluntary, if I refuse to sign this consent, Questcare Medical Clinic may refuse to treat me.

\_\_\_\_\_ **Minor/Disabled Patient:** If I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Questcare Medical Clinic that I have the legal authority to consent to treatment on the patient's behalf and that I do in fact consent to treatment as described in the preceding paragraph. In such a case, references in this form to "I", "me", or "my" are intended as references to the patient where appropriate in the context.

\_\_\_\_\_ **Exposure Testing:** I understand that in the case of an accidental exposure to blood or other bodily fluids, state law allows Questcare Medical Clinic to perform an HIV test without obtaining the patient's consent on a patient who may have exposed a healthcare worker to HIV.

\_\_\_\_\_ **Patient Responsibility for Follow-Up:** I understand that it is my responsibility to follow any discharge and/or follow-up instructions Questcare Medical Clinic may provide to me, including without limitation any recommended home-care and any follow-up examination and/or treatment by other healthcare providers. I accept full responsibility for the consequences of any failure by me to obtain recommended follow-up care and/or to comply with any other discharge instructions related to this Questcare Medical Clinic visit.

\_\_\_\_\_ **Responsibility for Payment:** In consideration of the services Questcare Medical Clinic will provide to me, I promise to pay Questcare Medical Clinic's charges for such services. I understand Questcare Medical Clinic may file its bill with my insurance company, but I understand that it is my responsibility to obtain any referral forms from my primary care physician that my insurance company may require as a condition to its payment for my healthcare service. I understand that the cost of healthcare services provided to me is my personal responsibility, even if I have insurance coverage for that cost, and that I am directly liable to Questcare Medical Clinic for any portion of such cost that my insurance company or other third-party payer does not pay, for any reason. If I am signing this form on behalf of a person whom I have allowed to be a dependent on my insurance coverage, I acknowledge that I am personally liable for any copayment, deductible obligation, or other portion of Questcare Medical Clinic's charge for services to that person that my insurance company or other third-party payer does not pay. If the patient is my minor child, I acknowledge that I am legally responsible to Questcare Medical Clinic for its charges for services to the patient without regard to the allocation of liability for such charges as between other persons and me in a decree of divorce or other court order or decree. I understand that if my account with Questcare Medical Clinic is unpaid for more than a reasonable amount of time Questcare Medical Clinic will place my account with a collection agency, and, if necessary, cause my unpaid account to appear on my credit report. I agree to endorse and forward to Questcare Medical Clinic all insurance or third-party payments that I receive for services Questcare Medical Clinic has rendered to me, immediately upon my receipt of such payments.

\_\_\_\_\_ **Medical Records:** I understand that Questcare Medical Clinic maintains medical records in the office which will be used on an ongoing basis for planning care and treatment. Information within the medical record may be released by Questcare Medical Clinic to my other physicians/healthcare providers and insurance company as necessary for billing and medical reasons. I authorize Questcare Medical Clinic to access by prescription history from external sources. **MEDICARE PATIENTS:** I authorize Questcare Medical Clinic to release my medical information to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for services to Questcare Medical Clinic.

\_\_\_\_\_ **Email:** If I have provided my email address on this form I understand that Questcare Medical Clinic will keep that address confidential and will not rent or sell it. I understand that Questcare Medical Clinic has requested my email address in case Questcare Medical Clinic needs to contact me. I consent to Questcare Medical Clinic's sending me, as a courtesy, patient follow-up communications, satisfaction surveys, or urgent notices. I consent to Questcare Medical Clinic sending unsecured emails regarding my Questcare Medical Clinic visit to the email address I have provided on this form.

\_\_\_\_\_ **Consent to Wireless Telephone Calls:** I consent to receive telephone calls, SMS/texts, and other communications on my cellular phone, other phone(s), and other communications devices, including autodialed calls and prerecorded messages from Questcare Medical Clinic, its successors, assigns, affiliates, agents, independent contractors, servicers, and collection agents. I understand these calls may regard my visit to Questcare Medical Clinic or financial obligations related to my visit.

\_\_\_\_\_\*I acknowledge that I have received or been given the opportunity to receive a copy of Questcare's HIPAA Privacy Policy and understand that if I have any questions or complaints, I should contact the Questcare Medical Clinic's Privacy Officer at 214.217-1911.

\* \_\_\_\_\_ (Patient/Guardian Initials)

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Signature of Patient, Parent, or Legal Guardian

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Date