

# Patient Registration Form

## Patient Information:

\_\_\_\_\_  
Last Name First Name Middle Name

\_\_\_\_\_  
Gender Social Security # Marital Status Date of Birth

\_\_\_\_\_  
Race Hispanic or Latino Not Hispanic or Latino Ethnic Group Preferred Language

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Home Phone Cell Phone Work Phone Email Address

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
*(Someone outside of household if possible)*

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Employer/Company: \_\_\_\_\_

## Guarantor Information:

If the above patient is under the age of 18 or they are not the insurance policy holder, please fill out the information below.

\_\_\_\_\_  
Last Name First Name Middle Name

\_\_\_\_\_  
Date of Birth Gender Social Security # Martial Status

\_\_\_\_\_  
Home Phone # Work Phone # Cell Phone # Relationship to Patient

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer/Company: \_\_\_\_\_

Please list the other members of your household

<u>Name</u>	<u>Date of Birth</u>	<u>Sex</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Acknowledgment of Consent

By executing this agreement, I accept the following terms of treatment that are required by Family Medical Center of Hart County (FMC):

**Consent for Medical Treatment:** I consent to routine diagnostic procedures and medical treatment by Family Medical Center of Hart County. I understand that no guarantee of results has been made.

**Protected Health Information:** I consent to the use and disclosure of my protected health information, by Family Medical Center of Hart County, to carry out treatment, payment, or health care operations. I acknowledge receipt of a copy of the HIPAA Privacy Notice which provides a complete description of such uses and disclosures, and that I have the right to review the policy notice prior to signing this consent.

I understand that I have the right to cancel this consent, in writing, at any time. If I cancel this consent, I understand that information may have already been used or disclosed about me and that only future disclosures will be affected.

**Insurance Authorization/Assignment:** I assign the authorized benefits of my medical insurance (including any Medicare, Medicaid, or Medigap plans) to be made on my behalf to Family Medical Center of Hart County for any services furnished to me. I authorize payment of the assigned benefits directly to Family Medical Center of Hart County. I authorize Family Medical Center of Hart County to release medical information to the Social Security Administration or its intermediaries or carriers as required for payment of claims.

Family Medical Center of Hart County has the right to change its privacy terms and practices which are described in the privacy notice. A sign will be posted at the front desk to notify patients of any changes and how to get an updated copy.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Responsible Party (If not the Patient)

\_\_\_\_\_  
Relationship to Patient (If not the Patient)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OF HART COUNTY**

**Financial Policy**

**Insurance:** Insurance is a contract between you and your insurance company. You are responsible for knowing the coverage of your plan. Your insurance determines your benefits. You agree to pay any portion of the charges not covered by insurance.

**Payment Options:**

1. If you have health insurance, we will bill your primary and secondary for your visits. You agree to pay any portion of the charges not covered by insurance. All co-payments are due at time of service.
2. If you don't have health insurance, you are responsible for paying your bill in full. Patients that pay their bill in full at the time of service will receive a percentage discount.

**Financial Assistance:**

1. Low income patients may be eligible to receive a percentage discount based on income level.
2. Financial assistance may only be authorized by our account specialist.

**Monthly Statement:** If you have an unpaid balance on your account, we will send you a monthly statement, however, absence of a statement does not relieve of your responsibility for payment.

**No Show/Cancellation Fee:** You may be charged a fee if you no show or cancel your appointment without giving a 24 hour notice.

**Returned Checks:** There is a \$40.00 fee for any checks returned by the bank.

**Newborn Care:** As a courtesy, we will see newborns that have insurance coverage pending for the first 30 days without requiring payment. Infants over 30 days old without active insurance will be required to pay at time of service.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. Family Medical Center reserves the right to verify employment of any patient. The undersigned agrees that if this account is not paid when due, and Family Medical Center should retain an attorney or

collection agency for collection, to reimburse Family Medical Center the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3 percent of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable interest and reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing. In case of suit, you agree the venue shall be in Hart County, Kentucky. We shall have the right to refuse future service to any accounts that are referred to a lawyer or a collection agency.

**Workers Compensation:** We require authorization by your employer or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for full payment. At your request, we will submit the claim to your medical insurance with a copy of the workers' compensation insurance denial if furnished.

**Personal Injury/MVA/Car Accident:** It is your responsibility to file a report with the liability or automobile insurance. We will bill your personal injury protection (PIP) insurance or other liability insurance if the information is furnished in a timely manner. If not paid within 30 days from filing, the bill responsibility will be transferred to you. If an attorney is involved in your case, we need their contact information. We do not accept a signed attorney lien as a method of payment nor are we in a position to defer payment obligations while a case settles. If your PIP benefit is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information in a timely manner. Ultimately, you are responsible for payment of the services.

**Divorce:** In case of divorce/separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent bringing the child in will be asked for payment regardless of the guarantor. If the divorce decree requires the other parent to pay any of the treatment costs, the authorizing parent is responsible for collecting from the other parent.

***By signing this agreement, you are responsible for payment of all services that are received.***

Patient Name: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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



117 West South Street  
PO Box 579  
Munfordville, KY 42765

Phone: (270) 524-7231  
Fax: (270) 524-7415  
www.MunfordvilleFMC.com

OF HART COUNTY

## New Patient Adult History Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer/Military Service: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

\_\_\_\_\_  
Name of Previous Family Provider City State

### Allergies

- Allergy Injections Allergist Name: \_\_\_\_\_  
 Food Allergy  
 Seasonal Allergies  
 Year Round Allergies  
 Latex Allergy  
 Any Other Known Allergies \_\_\_\_\_

Has the patient ever had an allergic reaction to:

- Medication  Yes  No **If yes:** \_\_\_\_\_  
 Injection  Yes  No **If yes:** \_\_\_\_\_

### Tobacco/Caffeine/Alcohol History

(Check all that apply)

- Tobacco Use  Yes  No  
**If yes:**  Current **Used for how long:** \_\_\_\_\_  Past **Last used:** \_\_\_\_\_  
Tobacco type used:  Cigarettes # packs per day \_\_\_\_\_  Cigar/Pipe  Smokeless Tobacco
- Alcohol Use  Yes  No  
 Consume Daily **Amount Consumed** \_\_\_\_\_  
 Consume Weekly **Amount Consumed** \_\_\_\_\_  
 Consume Monthly **Amount Consumed** \_\_\_\_\_
- Caffeine Use  Yes  No (Caffeine is found in soda, coffee, tea)  
 Consume Daily **Amount Consumed** \_\_\_\_\_  
 Consume Weekly **Amount Consumed** \_\_\_\_\_  
 Consume Monthly **Amount Consumed** \_\_\_\_\_
- Drug Use  Yes  No **If yes, list drug(s) used below:**  
**Drug(s):** \_\_\_\_\_

**Hospital/Surgery History**  
 (List any hospital admissions or surgeries)

**Admission/Surgery Type:**

**When:**

**Where:**

---



---



---



---



---



---

**Current Problems**  
 (Check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Pleurisy<br><input type="checkbox"/> Stomach Ulcer<br><input type="checkbox"/> Kidney Stone or Infection<br><input type="checkbox"/> Seizure<br><input type="checkbox"/> ADHD<br><input type="checkbox"/> TIA<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> OCD<br><input type="checkbox"/> Cancer <b>Type:</b> _____ | <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Enlarge Heart<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Gallstones<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Alzheimer's<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Depression<br><input type="checkbox"/> PTSD | <input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Phlebitis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Hives<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> STD<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Cataract<br><input type="checkbox"/> Bipolar<br><input type="checkbox"/> Schizophrenia |
|--|---|---|

**Current Medications**

(List ALL medications you are currently taking below)

**Medication Name**

**Dosage**

**Directions**

---



---



---



---



---



---



---



---



---



---



---

## Family History

Father:  Living  Deceased **If deceased, cause of death:** \_\_\_\_\_

Mother:  Living  Deceased **If deceased, cause of death:** \_\_\_\_\_

Brothers: # Living \_\_\_\_\_ # Deceased \_\_\_\_\_

**If deceased, cause of death:** \_\_\_\_\_

Sisters: # Living \_\_\_\_\_ # Deceased \_\_\_\_\_

**If deceased, cause of death:** \_\_\_\_\_

(Check all answers and family members that apply)

(F=Father; M=Mother; MGF=Maternal Grandfather; MGM=Maternal Grandmother; PGF=Paternal Grandfather; PGM=Paternal Grandmother)

- |  |                            |                            |                              |                              |                              |                              |
|--|----------------------------|----------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> TIA                 | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> ADHD                | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Alzheimer's         | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Cataract            | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Mental Retardation  | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Bipolar             | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> OCD                 | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> PTSD                | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Alcohol Abuse       | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> F | <input type="checkbox"/> M | <input type="checkbox"/> MGF | <input type="checkbox"/> MGM | <input type="checkbox"/> PGF | <input type="checkbox"/> PGM |

**Type of cancer:** \_\_\_\_\_

Other Diseases \_\_\_\_\_

**FAMILY MEDICAL CENTER OF HART COUNTY  
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

**Your Health Information Rights**

The health and billing records we maintain are the physical property of Family Medical Center of Hart County. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information in writing.
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
3. Right to inspect and copy your health record and billing record by delivering the request in writing.
4. Right to request your health care record be amended to correct incomplete or incorrect information by written request to our office.
5. Right to request in writing that communication of your health information be made by alternative means or at an alternative location
6. If you want to exercise any of the above rights, contact Brenda Caswell, HIPAA Officer, in person or in writing, during normal hours.
7. You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

**Our Responsibilities**

1. Maintain the privacy of your health information as required by law;
2. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
3. Abide by the terms of this Notice;
4. Notify you if we cannot accommodate a requested restriction or request; and
5. Accommodate your reasonable requests regarding methods to communicate health information to you.
6. Accommodate your request for an accounting of disclosures.
7. We reserve the right to amend, change, or eliminate provision in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice". You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

**To Request Information or File a Complaint**

Contact Brenda Caswell, HIPAA Officer, for questions or if you want to report a problem regarding the handling of your information. OR you may file a complaint by mailing it to the Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, GA 30303-89009, telephone 404-562-7886, Fax 404-562-7881

- We cannot and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

**Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule**

**Patient Contact:** We may contact you to provide you with appointment reminders, information about treatment alternatives, or with information about other health-related benefits and services that may be of interest of you.

**Opportunity to Agree or Object -Notification:** Unless you object, we may disclose your protected health information in the following manner:

- Notify or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and general condition, or your death.
- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care or in an emergency.
- To order to assist in disaster relief efforts.

**Opportunity to Agree or Object Not Required:** We may use or disclose your protected health information in the situations to the extent that the law requires or allows, without your authorization or giving you an opportunity to object to the release:

**Other Uses and Disclosures** besides those identified in this Notice will be made only as otherwise authorized by law or your written authorization ..

**Website:** We maintain a website that provides information about our entity; this Notice is on the website at [www.Munfordvillefmc.com](http://www.Munfordvillefmc.com)

**Effective Date of this Notice:** April 14, 2003 **Revised:** September 2003, February 28, 2009, October 2011