PATIENT REGISTRATION PACKET

Please Print clearly and Fill in all Areas on all 4 Pages	❑ New Patient ❑ Existing/Update

PATIENT INFORMATION

First name:	Last:	M.I.	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status *(circle one)* Single / Married / Divorced / Widow
Social Security #: / /	Date of Birth: / /	Sex: ❑ M ❑ F	Student: *(circle one)* Yes or No *(circle one)* Part-Time or Full-Time	
Home address:		City:	State:	Zip Code:
Please list contact number (to the right) in the order we should call you.	Primary Phone #: (*This # will be used for appt reminders)* ( ) Home Cell Work		Secondary Phone #: ( ) Home Cell Work	
	Employer:	Full-Time or Part-Time	Employer Phone #: ( )	
E-mail Address: *(For communication/reminders and/or Portal Set Up)*				

MEANINGFUL USE CRITERIA

To be able to fulfill the Meaningful Use criteria please provide the information below

Race *(select at least one)* ❑ White ❑ African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Refuse to Report

Ethnicity *(Please select only one)* ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Refuse to Report

Language Best Served:

RESPONSIBLE PARTY INFORMATION

(If patient is child, who do they reside with)

Full Name:	Phone #:	Relationship to patient: ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Step-Father ❑ Step-Mother ❑ Other	
Mailing Address:	City:	State:	Zip Code:

Is this patient covered by insurance? ❑ Yes ❑ No *(If yes, proceed to next section)*

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist)

PRIMARY Insurance Policy Holder: ❑ Patient ❑ Father ❑ Mother ❑Step-Father ❑ Step-Mother ❑ Other

Policy Holder's Full Name:		Policy Holder's Social Security #: / /	Policy Holder's Date of Birth: / /
Policy #:	Group #:	Employer:	Employer Phone #: ( )

SECONDARY Insurance Policy Holder: ❑ Patient ❑ Father ❑ Mother ❑Step-Father ❑ Step-Mother ❑ Other

Policy Holder's Full Name:		Policy Holder's Social Security #: / /	Policy Holder's Date of Birth: / /
Policy #:	Group #:	Employer:	Employer Phone Number: ( )

My signature confirms that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration.

_______________________ *(Printed Name)*

_______________________ *(Signature)*

_______________________ *(Date)*

Notice of Privacy Practices/ Phone Message/ Contact Authorization
Pharmacy Information

Patient Name: ____ Date of Birth: _____________________

NOTICE OF PRIVACY PRACTICE

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your medical records. It also describes your rights with respect to your medical records. **Please read it.**

- We will use and share your health records to treat you and bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

I understand that the NPP is available on the Holm Medical Clinic website (www.holmclinic.com) and at my physician's office. **I acknowledge receipt of the Holm Medical Clinic Notice of Privacy Practices (NPP).**

Signature of Patient: ____ Date: ___________________

Signature of Authorized Representative: _________________________________ Date: __________

Name of Authorized Representative: ___________________________ Date: ____________________

PHONE MESSAGE AND CONTACT AUTHORIZATION:

Please CHECK the appropriate answer below:

Do the providers and staff of Holm Medical Clinic have your permission to leave messages containing to medical and/or financial information on your answering machine/voice mail?

At home	_______ Yes	_______ No *	Phone # _______________________
At work	_______ Yes	_______ No *	Phone # _______________________

IF YOU CHECK "NO", THE DATE, TIME AND LOCATION OF APPOINTMENTS WILL BE THE ONLY INFORMATION LEFT ON YOUR ANSWERING MACHINE/VOICE MAIL.

The individual(s) named below will also be your emergency contact(s) unless you specify otherwise.
Please complete below: I give authorization to the providers and staff of Holm Medical Clinic to discuss my medical and/or financial with the following people- **If you do not provide this information Holm Medical Clinic will not be able to discuss your health records with spouse, children etc..**

	Name	Relationship	Phone #
(1)	_________________________________	____________________	________________
(2)	_________________________________	____________________	________________
(3)	_________________________________	____________________	________________

PHARMACY INFORMATION

Local Pharmacy You Use: *(Include location)*	Mail Order Pharmacy *(Optional)*	I.D. #

I understand it is my responsibility to inform Holm Medical Clinic of any desired changes in this authorization.

Signature: ____ Date: _______________________

PATIENT FINANCIAL POLICY

Patient Name: ____ Date of Birth: _____________________

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. Holm Medical Clinic will file for insurance benefits and accept payments per Holm Medical Clinic contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by Holm Medical Clinic is given strictly as a courtesy and implies no responsibility on Holm Medical Clinic's part for filing, follow through or confirmation. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered.

RETURNED CHECK FEE

I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services.

PAST DUE ACCOUNTS

If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize Holm Medical Clinic to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating and I may be discharged from Holm Medical Clinic.

PAYMENTS

We accept cash, debit cards, Visa, MasterCard, personal checks and money orders. Any outstanding balances are due within 30 days of the statement.

SELF-PAY PATIENTS

A 15% cash discount will be given for provider fees for those patients who do not have insurance or wish not have their insurance filed. Payment in full must be made at the time of check out to receive the discount.

NO SHOW CHARGE

I understand I may be charged a $25.00 fee for missed appointments that are not cancelled at least 24 hours in advance.

AUTO ACCIDENTS

Payment for all services is due at the time of service. Receipts will be given for you to seek reimbursement.

TREATMENT OF MINORS/DIVORCE DECREES

If the patient is a minor, the parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility.

REFERRALS AND AUTHORIZATIONS

If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not Holm Medical Clinic to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform Holm Medical Clinic immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

LAB WORK

Many insurance companies require a specific laboratory be utilized. If your policy requires a laboratory other than **SOUTH BEND MEDICAL FOUNDATION**, please inform the nursing staff at each visit.

Consent for Treatment

CONSENT FOR TREATMENT

I request and give consent to my medical provider to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my provider for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

I have read, understand and agree to comply with these policies.

______________________________ Signature of Patient	____________________ Date

______________________ Signature of Authorized Representative	______________ Relationship to Patient	______________ Date

AUTHORIZATION AND ASSIGNMENT

Patient Name: ______________________________________ Date of Birth: ____________________

CERTIFICATION
I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

INSURANCE PARTICIPATION
Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. However, there are several points we would like to mention:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- You are expected to pay your co-payment at each visit when you check in.
- If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be aware of your coverage and be prepared.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS
I do hereby authorize Holm Medical Clinic to apply for benefits for services rendered to myself or minor child(ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to Holm Medical Clinic (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to Holm Medical Clinic. I authorize Holm Medical Clinic to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize Holm Medical Clinic to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare & Medicaid Services CMS, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Holm Medical Clinic; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to Holm Medical Clinic as required for payment of benefits and/or required for medical or any other reasons; and authorize Holm Medical Clinic to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Patients requesting a permanent transfer of records or copies for personal reasons may incur a charge. Record Copy Fee: Minimum charge is $10.00 or $1.00 for 1st 10 pages, $0.50 per page for pages 11-50, and $0.25 for each page in excess of 50.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

I understand that Holm Medical Clinic agrees to bill my health insurance carrier as a courtesy to me. I must submit information as needed by my insurance carrier or Holm Medical Clinic to guarantee payment for services rendered to me. I understand I am ultimately responsible for payment of all services.

______________________________________ ______________________
Signature of Patient Date

______________________________ ______________ ______________________
Signature of Authorized Representative Relationship to Patient Date

PATIENT PORTAL

Our Electronic Medical Record Company has developed a program that allows patients to access their health information through a secure internet portal, similar to logging into a bank's website to view your checking account. The services available through the portal are no different than one would receive by calling our office; the portal is simply a convenience for our patients. Access to your health information through the portal is only available with your signed request along with a picture ID. With your portal access you will receive a secure email account to ensure that messages sent and received through the portal are private. No sensitive information will ever be sent outside of the portal. All messages within the portal will become a part of your permanent medical record.
If you are interested in receiving a username to the patient portal please ask at the front desk.