DEVON FAMILY PRACTICE PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____ First:_____ Middle:_____

Address:_____ Apt:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

May We Leave a Message? Yes or No Where can message be left? Home Work Cell

Email address:_____

Social Sec #:_____ Date of Birth:_____ Sex: Male or Female

Marital Status: Single Married Divorced Widowed Spouses Name:_____

Race: American Indian Asian African American Native Hawaiian White Other _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other _____

Preferred Language: _____

INSURANCE INFORMATION:

Insurance Co: _____ Policy #:_____

Address, City, State:_____ Group #: _____

Subscriber Information (if different from patient) :

Name:_____ Social Sec #: _____

Date of Birth: _____ Relationship to Patient:_____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____ Occupation:_____

Address, City, State:_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____ Relationship: Spouse Parent Child Other

Address, City State: _____

Home Phone #:_____ Work Phone #_____ Cell #:_____

PHARMACY INFORMATION:

Local Pharmacy :_____ Phone #: _____

Address, City, State: _____

Mail Order Pharmacy :_____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Devon Family Practice to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or Co-Insurance payments.

_____ _____ _____

Patient or Guardian Signature Date

DEVON FAMILY PRACTICE LLP (DFP)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for DFP to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of Privacy Practices provided by DFP describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. DFP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to DFP, 139 Berkeley Road, Devon, PA 19333.

With this consent, DFP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others:

With this consent DFP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, DFP may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that DFP restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow DFP to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, DFP may decline to provide treatment to me.

Signed by: _____

Signature of Patient or Legal Guardian

_____

Print Name of Legal Guardian, if applicable

_____

Print Patient's Name

_____

Relationship to Patient

_____

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Devon Family Practice's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Devon Family Practice may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Devon Family Practice's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Devon Family Practice's *Notice of Privacy Practices*.

Printed Patient Name

Patient Signature

Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name

Relationship to Patient

Patient Personal Representative Signature

Date

For Devon Family Practice Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Devon Family Practice made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other _____

Printed Employee Name

_____

_____

DEVON FAMILY PRACTICE

HIPAA RELEASE FORM

Patient's Name: _____

Date of Birth: _____ Phone: _____

According to the Health Insurance Portability Accountability Act (HIPAA) regulations, we are required to keep your health information confidential. You have the right to restrict family members or other persons from accessing your health information. However, we are aware that many of our patients do not wish to restrict their spouse, family member, or other person from having access to their health information. In an effort to comply with HIPAA regulations, and to avoid inconveniences for our patients we are asking that you please complete this form. If at any time you wish to change any of the information on this form, please notify our office in writing.

The parents or legal guardians of a minor will always have access to medical information. In the case you would like to designate additional individuals to have this access, please list them below. Health information would include your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment, and procedures). You are not required to list anyone, but if you do, you are authorizing that person to have complete access to your medical and/or payment information.

Please mark the type of access you would like them to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Obtain/ Authorize Release of Medical Records

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Name: _____

(please print)

Patient Signature: _____ Date Signed: _____