



# WOODLAND HEIGHTS FAMILY PRACTICE AT BRENTWOOD

## PATIENT REGISTRATION FORM

SOCIAL SECURITY #	PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORKPHONE	CELLPHONE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
EMPLOYER		EMPLOYER ADDRESS		
EMPLOYER PHONE		EMAIL ADDRESS		
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPERATED <input type="checkbox"/> OTHER		

### PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

CHECK IF SAME AS ABOVE / IF NOT, PLEASE COMPLETE BELOW

RELATIONSHIP TO PATIENT	GUARANTOR'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
SOCIAL SECURITY #	EMPLOYER	EMPLOYER PHONE		
EMPLOYER ADDRESS		EMAIL ADDRESS		

### SPOUSE INFORMATION

CHECK IF SAME AS ABOVE / IF NOT, PLEASE COMPLETE BELOW

FIRST NAME		LAST NAME		
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	DATE OF BIRTH	
SOCIAL SECURITY #	EMPLOYER	EMPLOYER PHONE		
EMPLOYER ADDRESS		EMAIL ADDRESS		

### EMERGENCY CONTACT

CHECK IF SAME AS PERSON RESPONSIBLE FOR PAYMENT / IF NOT, PLEASE COMPLETE BELOW:

NAME	HOME PHONE	CELL PHONE	WORK PHONE	RELATIONSHIP TO PATIENT
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ADVANCED DIRECTIVES / LIVING WILL:  YES  NO

 **WOODLAND HEIGHTS  
FAMILY PRACTICE AT BRENTWOOD**  
**REGISTRATION CONSENTS  
AND ACKNOWLEDGEMENTS**

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**PRIVACY ACKNOWLEDGEMENT**

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? Yes No

If no, is there another number at which we may try to reach you? \_\_\_\_\_

2. May we mail to the address you provided information regarding your appointment or test results?

Yes No If no, is there another address at which we may send you information?

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3. Do you wish us to share health information regarding you with a family member or friend?

Yes No If yes, please provide name of person(s). \_\_\_\_\_

4. May we contact you via e-mail with information about our practice, educational programs and general health information?

Yes No If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

NOTE: To protect your information, we reserve the right to use professional judgment and discretion when communicating information/ test results which may be "sensitive" in nature.

I have received a copy of Woodland Heights Family Practice at Brentwood Group's "Notice of Privacy Practices for Protected Health Information."

**REFERRALS FOR SERVICES**

Welcome to the Woodland Heights Family Practice at Gaslight. In an effort to make treatment for our patients as enjoyable and timely as possible, our department has adopted the following policy regarding scheduling and cancelations. If you are up to **15 minutes** late, your physician may not be able to see you. Please understand that if you are treated, your treatment may be modified to accommodate other scheduled patients. If you are **30 minutes** late, you may need to reschedule your appointment for another time. Failure to keep **3** scheduled appointments without giving notice may result in your discharge from the physician. Failure to keep **5** scheduled appointments, even with advance notice, will result in your discharge from physician.

**CONSENT TO TREAT**

I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HBV, Hepatitis C virus or HCV, and Human Immunodeficiency Virus or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.



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## REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

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### FINANCIAL AGREEMENT

Patient and/or guarantor is responsible for charges incurred. Any charges shall be based on the prevailing rate for the specific services rendered or items provided, that is in effect in the charge master on the date such services are rendered or items provided. It is a courtesy of our office to file your insurance; however you are responsible for your co-pay and/or percentage which the insurance company is not liable for on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, and you agree to be responsible for additional expenses incurred (if applicable including but not limited to, court costs and attorney fees) if legal action is necessary for collections.

By signing this form I am authorizing contact for purposes of financial matters and account collection through any telephone number provided. Patient and/or guarantor agrees to permit Woodland Heights Family Practice at Brentwood or its agents to review financial ratings and credit reports when necessary. I have read and fully understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to this medical practice. I also authorize the release of any information acquired in the course of my treatment to my insurance company or any third party obligated to pay all or part of my medical bill as needed to issue benefits.

To insure the accuracy of your information, photo identification is required. Without photo identification, we require your photograph. I certify that all identification information is true and correct. I understand that providing false identification is a crime and may be reported to local law enforcement.

### CONSENT TO PHOTOGRAPH:

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that Woodland Heights Family Practice at Brentwood will retain ownership rights to these recordings or other images, but that I will be allowed to view them or obtain copies. I understand that these images will be stored in a secure manner to protect my privacy and that they will be kept for the time period required by law or Woodland Heights Family Practice at Gaslight's policy. Images that identify me will be released and/or used only upon written authorization from me or my legal representative.

### MEDICARE AND MEDICAID INFORMATION

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I further certify that I have provided any required information concerning any other liability for medical practice charges in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf.

I authorize Woodland Heights Family Practice at Brentwood to secure information from the Department of Human Services regarding my qualification for Medicaid.

BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT.

Patient / Authorized Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If Authorized Representative, relationship to Patient: \_\_\_\_\_

If person other than patient is responsible for payment:

Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_