SSD MEDICAL GROUP
Patient Registration Form

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: M ___ F ___
Last First MI

Home Address: _____ City: _____ State: _____ Zip Code: _____

Social Security No: _____ Home Phone_____ Cell Phone: _____

Ethnicity: Hispanic or Non-Hisp Race: _____ Preferred Language: _____ Translator Needed?: ____

E-mail Address: _____ Would you like to access your chart electronically?: _____

Employer Information:

Employer Name: _____ Work Phone: _____

Employer Address: _____ City: _____ State: ____ Zip Code: _____

Insurance Information:

Primary Ins. Company: _____ Subscriber Name: _____

If subscriber different than patient: Relationship to Patient: _____ Date of Birth: _____

Secondary Ins. Company: _____ Subscriber Name: _____

If subscriber different than patient: Relationship to Patient: _____ Date of Birth: _____

In Case of Emergency:

Contact Name: _____ Relationship to Patient: _____ Phone: _____

Contact Name: _____ Relationship to Patient: _____ Phone: _____

Pharmacy:

Name: _____ Location: _____ Phone: _____

How did you hear about us?:

☐ Friend/Family ☐ Insurance ☐ Internet ☐ Newspaper ☐ Flyer/Mailer ☐ Other: _____

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to SSD Medical Group or its agent all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company.
I authorize SSD Medical Group to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to SSD Medical Group which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part the medical services which I have received. The authorization and assignment shall be valid until I notify SSD Medical Group in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature: _____ Date: _____

Medical Services Financial Policy & Agreement

The terms and conditions that apply to the care, treatment and other services provided by or through SSD Medical Group or at any of SSD Medical Group's facilities are set forth below. Please read these terms and conditions very carefully.

Insurance:

You will be asked to update your personal insurance information at each visit to our office, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Please assist us with complying with your insurance requirements.

We will gladly submit feed for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.

✖ _____ ***PLEASE INITIAL***

Payment for Services:

Payments for services, including insurance co-payment or self-pay balance amount are due at the time services are rendered unless payment arrangements have been approved in advance by the billing department. We accept cash, checks, Mastercard, Visa and Discover. Our failure to collect these armounts may be a violation our contract with your insurance company. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company representative.

✖ _____ ***PLEASE INITIAL***

Fees:

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hour notice. Your cooperation in cancelling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs medical care. **Failure to show for a scheduled, confirmed appointment may result in a $35 cancellation fee.**

Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court feed. **Returned checks will result in a $25 fee that will be posted to your account.**

✖ _____ ***PLEASE INITIAL***

General:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, and not your insurance company.

Medical Services Financial Policy & Agreement (Continued)

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Financial Agreement:

I agree to pay for all care, treatment, and other related services provided to me (or the person identified below) by SSD Medical Group or the independent physicians described above, or at any of SSD Medical Group's facilities. No assignment of benefits or acceptance of partial reimbursement shall be deemed a waiver of SSD Medical Group's right to require full payment of all amounts associated with such care, treatment or other related services. I acknowledge that I will be charged, and agree that I will pay interest (at a rate no higher than the maximum permitted by law) on any overdue amounts until they are paid in full (if necessary). If my account is referred for collection, I agree to pay for all costs of collection, including reasonable attorneys' fees and court costs. I understand and agree that any overpayments collected by SSD Medical Group with regard to any particular care, treatment or other services provided to me may be applied to any outstanding amounts then due and payable to SSD Medical Group for which I am legally responsible. If for any reason, I cannot give a 24-hour notice for cancellation, I will be charged a NO SHOW penalty. All phone consultations will be billed.

Assignment of Benefits:

I irrevocably assign and transfer to SSD Medical Group, all health, medical or other related benefits payable on my behalf (or on behalf of the person identified below) under any contract of insurance or from any other source; governmental or private. I authorize SSD Medical Group to directly received payment of such benefits. I acknowledge and understand that SSD Medical Group is responsible for determining the existence or extent or any insurance or other benefits that may be payable for care, treatment or other services provided to me. I agree that I am solely responsible for all charges incurred with regard to such care, treatment and services, regardless of the existence or extent of insurance coverage (including, any deductibles, co-insurance or co-payment amounts associate with any such insurance coverage).

Acceptance and Signature

I represent that I, as either the person identified below or such person's legal representative, have read and understand, and am duly authorized to accept and execute these terms and conditions. Any questions that I've had have been satisfactorily answered. I hereby accept and agree to be bound by all of the above terms and conditions and I agree that a copy of this document may be used in place of the original in enforcing any rights hereunder.

Printed Name: _____

Signature: _____ Date: _____

Patient Communications Consent

Introduction: It is the physician's responsibility to ensure that the physician-patient relationship is confidential. HIPAA allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information.

Medical Information

Please indicate what numbers we should contact you at, as well as if it is okay to leave a message containing medical information on any voicemail or answering machine.

Home Phone: (_____) _____-_____ Ok to leave message?: ☐ Yes ☐ No

Work Phone: (_____) _____-_____ Ok to leave message?: ☐ Yes ☐ No

Cell Phone: (_____) _____-_____ Ok to leave message?: ☐ Yes ☐ No

Appointment Reminders

We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment. ***Please initial*** *below whether or whether not it is okay to leave a specific message regarding confirming future appointments:*

_____ Yes – SSD Medical Group can call and leave a message to confirm/remind of any future Appointments.

_____ No – SSD Medical group cannot call and leave a message to confirm/remind of any future Appointments.

Release of Medical Information to Family Member(s) and Non-Family Members

You may also leave a message and medical information with the following person(s):

Name: _____ Relationship: _____ Phone: (_____) _____-_____

Name: _____ Relationship: _____ Phone: (_____) _____-_____

☐ I DO NOT want to designate any person to be able to speak to SSD Medical Group on my behalf

Authorization and Signature

I hereby give permission to SSD Medical Group through its physicians and staff to contact me or my designated person (if applicable) according to the information listed above, in regards to my medical conditions, medical needs or the status of my account. I release SSD Medical Group physician's and staff from any claim of confidentiality in connections with the release of this information.

Printed Name: _____

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices & Patient Rights

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition related to healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services to the extent necessary for the submission, processing and payment of any claim for benefits related to the provision of care, treatment or other related services to you. You understand that this may, at times, include information and records related to the diagnosis and treatment of mental illness, drug and alcohol abuse, and the results of blood tests performed to determine the presence of infectious diseases (including, for example, HIV"). For example, obtaining approval for a hospital stay that may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, risk management, accreditation purposes, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information

1. You have the right to inspect and copy your protected health information:

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPAA Notice of Privacy Practices & Patient Rights (Continued)

2. You have the right to request a restriction of your protected health information:

This means you may ask use not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

3. You have the right to request to receive confidential communications from use by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us:

Upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

4. You have the right to request a physician amendment to your protected health information:

If we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

6. Complaints

You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

Consent and Conditions for Treatment

The terms and conditions that apply to the care, treatment and other services provided by or through SSD Medical Group or at any of SSD Medical Group's facilities are set forth below.
Please read these terms and conditions very carefully.

I, the individual whose signature appears below, either on my own behalf or on behalf of the person identified (whom I am legally authorized to represent), hereby authorize and voluntarily consent to all care, treatment, and other related services (including, for example, diagnostic procedures, tests, radiology, anesthesia, emergency care, the administration of fluids and medications, and other nursing, medical, and surgical treatment and care) that may be ordered, requested, directed, or provided by my physicians or any emergency room physicians, or their associates, assistants or designees (including consulting physicians), or carried out at the request or direction of any of the foregoing individuals by members of SSD Medical Group's medical staff or other of SSD Medical Group's personnel. I understand that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made, or can be made, regarding any care, treatment or other related services that may be provided by our through SSD Medical Group.

I understand that I am free to select any primary or attending physician to provide care, treatment, or other services to me. If I do not know of a qualified physician to select, I understand that one option that I have is to request SSD Medical Group's assistance in identifying physicians authorized to practice at SSD Medical Group in the specialty

area that I require, but I agree that providing any such assistance, SSD Medical Group is not endorsing or recommending any particular physician.

Consent and Conditions for Treatment (Continued)

While I authorize and consent to call care, treatment and other services that SSD Medical Group may deem advisable under the circumstances (including emergency circumstances), I understand that, except in emergency circumstances, as a general rule, no substantial medical procedure will be performed upon anyone unless and until he or she has had an opportunity to discuss the procedure with the applicable physician or other healthcare professional. I understand that I have the right to consent to, or refused to consent to, any particular proposed medical procedure or course of treatment.

I authorize SSD Medical Group to disclose health related information and medical records about me to any person or entity (including, for example, my insurance company, employer or a private review organization) to the extent necessary for the submission, processing and payment of any claim for benefits related to the provision of care, treatment or other related services to me. I understand that this may, at times, include information and records related to the diagnosis and treatment of mental illness, drug and alcohol abuse, and the results of blood tests performed to determine the presence of infectious diseases (including, for example, HIV"). I consent to all such disclosures and waive any claims that may be available under federal or state law that such disclosures represent a breach of obligations of confidentiality. If in connection with my care or treatment, an employee of SSD Medical Group is exposed to my blood or bodily fluids, I authorize and consent to a sample of my blood being drawn and tested for infectious diseases of any nature or description.

I authorize SSD Medical Group to request an external prescription history from my insurance company; this will allow SSD Medical Group to reconcile my medications as needed for proper care.

I authorize the transmission of minimally necessary medical and other information via facsimile and/or electronic transmission, and hold SSD Medical Group harmless from any and all claims that might arise from risks of accidental disclosure of medical information, which is inherent in a facsimile and/or electronic transmission.

HIPAA Notice of Privacy Practices & Patient's Rights and Responsibilities Acknowledgment

I acknowledge that I have received a copy of this *HIPAA Notice of Privacy Practices & Patient Rights*. I further acknowledge that a representative of SSD Medical Group was available to explain this document and answer any questions that I may have asked regarding this document.

Consent and Conditions for Treatment Acceptance and Signature

I represent that I, as either the person identified below or such person's legal representative, have read and understand, and am duly authorized to accept and execute these terms and conditions. Any questions that I've had have been satisfactorily answered. I hereby accept and agree to be bound by all of the above terms and conditions and I agree that a copy of this document may be used in place of the original in enforcing any rights hereunder.

Printed Name: _____

Signature: _____ Date: _____