PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

PATIENT INFORMATION

***Last Name: ________________ *First Name: ______________ Middle Initial: ____________**

***Address: ____**

City: ________________________________ State: ____________________ Zip: ________________

Phone#:(________)________-____________*Social Security #: ______________________________

***DOB: ____________________ Age: _________ *Sex: _______ Marital Status: ____________**

Drivers Lic#: ______________ (please provide a copy of your ID, front and back)

INSURANCE INFORMATION:

PRIMARY INSURANCE: Please provide a copy of your insurance card, front and back.

SECONDARY INSURANCE: Please provide a copy of your insurance card, front and back.

All information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Alameda Acute Care Clinic & Family Medicine. I also authorize Alameda Acute Care Clinic & Family Medicine or Insurance Company to release any information required to process my claims.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Alameda Acute Care Clinic and Family Medicine or the medical provider individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Alameda Acute Care Clinic and Family Medicine is unable to collect from my insurance carrier for whatever reason. Failure to pay your remaining bill will result in collection. An account is generally considered delinquent at 60 days past due. I understand that if any amount due is not paid as agreed, my account is either turned over to a collection agency or attorney, I will pay all collection/legal fees incurred by Alameda Acute Care Clinic and Family Medicine, LLC.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Alameda Acute Care Clinic and Family Medicine or the medical provider on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Alameda Acute Care Clinic and Family Medicine Patient Information Privacy Policy. I hereby authorize Alameda Acute Care Clinic and Family Medicine or the medical provider individually to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Alameda Acute Care Clinic and Family Medicine representative or my medical provider to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Alameda Acute Care Clinic and Family Medicine to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Alameda Acute Care Clinic and Family Medicine physician or his or her designee.

Patient Financial Responsibility Policy

• Always bring your insurance card and I.D. to your appointment. If your coverage cannot be verified, you will be responsible for any payments at the time of service.
• It is your responsibility to notify us if there are any changes to your insurance, address, phone number or family status at check-in or sooner.
• It is your responsibility to pay for your unpaid balance, copay, coinsurance and/or deductible at time of service.
• If uninsured, it is your responsibility to pay your bill in full at time of service.
• If your insurance does not cover any office visit, specifically but without limitation, annual exams (particularly Medicare patients), and or diagnostic testing, and/or treatment, you understand.

Cancellation Policy

-To cancel/reschedule your appointment call us directly at 505-346-3704 or email us at support@aaccandfm.com If it is after hours please leave us a message with your name, date of birth, and date and time of your appointment.
I have filled out the above information to the best of my knowledge and verified the information to be accurate and true. I have read and understand the Patient Financial Responsibility Policy. I agree to be bound by the terms thereof, including without limitation the Cancellation Policy. I also understand that Alameda Acute Care Clinic & Family Medicine may amend such terms from time-to-time.

Clinic Policy & Acknowledgement

Dear patients,

Here is the notice for the clinic announcement, please read carefully. We understand that things happen and schedules do change and we ask that in the future you provide us with at least 24 hours notice for any appointment changes. Failure to provide at least a 24 hour notice for change of appointment will result in the following situation. We value your time and we hope that you do the same to us. Thank you so much.

* If you have an appointment and you would like to reschedule/cancel, please allow 24 hour notice; otherwise you will be charged a $25 fee. If we are not available to take your call, you can leave us a voicemail and that serves as your receipt of 24 hour notice. This fee is due prior to making the next appointment. Three missed appointments will result in dismissal from our practice.

* If you have an appointment and you do not show up or if you are running late more than 15 min, there will be a $25 fee. This fee is due prior to making the next appointment.

* If you have an unpaid balance that is 30 days past due on your account, you will need to pay this first before you can make the next appointment on the phone.

* If you need medication refills, please call your pharmacy to request refills. What they do, they will send us a request and we can approve it easily that way. Otherwise, all medication refills are normally done at the visit.
* If you receive 3 phone calls so far from us reminding you to make the next appointment, failure to do so will result in dismissal from our practice.

* During your visit, we normally assign about 30 min minimum for new patients and 15 min for follow-up patients to address most of your concerns. If you have more than 2 main problems, you will need to make a different appointment to discuss the other issues. This serves as a common courtesy to the next patient.

* **We also would like to let you know that our clinic does not treat CHRONIC PAIN. You will need to be referred to a pain specialist. We will no longer fill any opiate medications temporarily.**

NOTE: We also reserve the right to terminate the patient-provider relationship without providing a specific reason for withdrawal when the barrier to good quality of care exists.

Again, we appreciate you for choosing us as your primary care clinic. We would like to continue to provide excellent care for you and your family. If there are any unmet needs or concerns, please feel free to send us an email to support@aaccandfm.com. Thank you for your understanding.

HIPAA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers (e.g. my insurance company); The day-to-day healthcare operations of your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PATIENT NAME/GUARDIAN NAME (If Different):____________________________

PATIENT/GUARDIAN SIGNATURE: ________________________________**DATE:** _______________

CHIEF COMPLAINT (Two main reasons for today's visit)

PAST MEDICAL HISTORY (i.e: diabetes, high blood pressure, asthma, etc)

PAST SURGICAL HISTORY Procedure Age at time of procedure

1.
2.
3.

SOCIAL HISTORY

Smoke tobacco? If yes, how often?
Drink alcohol? If yes, how often? What do you drink?
Illicit drugs? If yes, how often? What type of drugs?

FAMILY MEDICAL HISTORY

Mom: alive or deceased
Dad: alive or deceased
Children:

MEDICATION ALLERGIES

Name Reaction

CURRENT MEDICATIONS:

Name Dosage Directions