NEW PATIENT REGISTRATION FORM

Date: _____

PATIENT INFORMATION

Name: (Last, First, Middle) _____ Maiden: _____

DOB: _____ Age: _____ Sex: _____

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

Phone#: (_____) _____ Alternate Phone #: (_____) _____

Email Address: _____ SSN: _____

Occupation: _____ Employer: _____

Employment Status: ____ Full Time ____ Part Time ____Unemployed ____Retired ____Student ____Other _____

Marital Status: ____Married ____Single ____Divorced ____Widowed

Race: ____ Asian __ __ Black or African American ____Native American ____ White/Caucasian ___ Other _____

Ethnicity: Do you identify with an Ethnicity origin? If yes, please note: _____

Spouse Name: (Last, First, Middle) _____Maiden: _____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: (_____) _____

Preferred Pharmacy: _____ Pharmacy Phone: (_____) _____

If the patient is a minor (under the age of 18) please provide information for the parent or legal guardian.

Parent/Legal Guardian: _____Phone: (_____) _____

How did you hear about us? ____Referral ____Social Med ____Internet ____Newspaper/Radio/TV _____ Mail

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____

Plan: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Secondary Insurance Company: _____ ID#: _____

Plan: _____ Group: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____Relationship to Patient: _____

INSURED INFORMATION (IF OTHER THAN PATIENT) – We will request to scan your ID and insurance card.

RELEASE OF INFORMATION

I hereby authorize to the person(s) listed below to receive information about the care of the above-named patient.

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

AUTHORIZATION TO RECEIVE HISCTORICAL PRESCRIPTION HISTORY

I hereby authorize MedNova Primary Care and its Affiliated Providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be reviewable by my providers and staff here and it may includer prescriptions back in time for several years. I understand that MedNova Primary Care and its Affiliated Providers will use my external prescription history to provide me with medical treatment and to evaluate and improve patient safety and the quality of medical care provided to me. I understand that I can revoke my permission at any time by giving written notice to my provider.

_____ _____

Patient Signature or Legal Representative **Date**

CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORNING

I consent to have my image taken by MedNova Primary Care for use of treatment, payment, or for health care operations. I understand that the image, including photographs, etc. will be for the purpose of assisting in my care, payment or health care operations including quality initiatives.

I understand that MedNova Primary Care will own these images; however, copies of them may be available at a reasonable cost. I may revoke or withdrawal this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

I certify this form has been fully explained to me and I understand its contents.

_____ _____

Patient Signature or Legal Representative **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize MedNova Primary Care to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to MedNova Primary Care.

I certify that the information I have reported with regard to my insurance is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to this medical group to apply to my account, should a balance exist.

Patient Signature or Legal Representative **Date**

CONSENT TO TREAT

I, the undersigned, as the patient or on behalf of the patient, whose name appears below, by means of this document give my consent and authorize the physician on duty and any of the health professionals designated to perform examination and routine diagnostic procedures upon me. I also consent to and authorize the physician to prescribe a therapeutic regimen, which I shall follow. Unless explicitly refuse, I consent that the treatment(s), diagnostic test(s), procedures(s), immunization(s) ordered by my physician or any of the health professional designated be performed on me despite risk involved and complications that might occur, which will be explained to me at the time they are ordered.

Patient Signature or Legal Representative **Date**

CONSENT FOR e CLINICAL MESSENGER

(Prerecorded messages delivered via an auto dialer that plays a message with a human or computerized voice.) By providing my telephone number(s), I agree to receive form MedNova Primary Care automated appointment reminder calls, prerecorded messages at the telephone number provided. I may revoke this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

Patient Signature or Legal Representative **Date**

MEDNOVA
PRIMARY CARE

Other Providers Participating in My Healthcare

Type	Name of Doctor	Phone number
Cardiologist		
Dermatologist		
ENT ear/nose/throat		
Gastroenterologist		
GYN		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psych (counselor)		
Pulmonologist		
Rheumatologist		
Urologist		

My last Primary Care Doctor was:

Name: _____

Phone Number: _____

MedNova Telehealth Consent Form

A telehealth service means that my visit with a medical provider at the distant site will happen by using audiovisual equipment. This consent is valid for 12 months for follow up Telehealth services with the health care provider.

I also understand that:

- I can decline the Telehealth service at any time by written, without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a provider in-person if I decline Telehealth services.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth services.
- I will have access to all medical information resulting from the Telehealth services as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to anyone else without my consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I will inform of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from anyone from any site during my Telehealth service.
- I may see an appropriate medical provider immediately after the Telehealth service if an urgent need arises.
- I also understand that my insurance will be billed for this visit with provider at MedNova Primary Care, and that I may be billed for what my insurance does not cover. I understand that if I have any questions about my billing, I will need to talk to the provider billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent id valid for twelve months and will be renewed after _____.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Legal Representative **Date**

[ ] Refused

Prescription Pick- up Authorization

Last Name:_____ **First Name:**_____

Date of Birth:_____/_____/_____

I hereby authorize the individual (s) listed below to pick up my prescribed prescription(s) from any of the Aegis Medical Group's locations. Aegis Medical Group's staff reserves the right to request proof of identity to pick up any prescriptions. My representative must be able to provide a valid photo identification. I further understand that any individual who is not listed will NOT be able to pick up my prescriptions. I am able to change this authorization at any time but understand that the changes MUST be submitted in writing to Aegis Medical Group.

Name of authorized person (please print legibly)	**Relationship to patient named above**

_____
Signature

_____
Date

Acknowledge for Advance Directive

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

*We would like a copy for our records.

_____I have executed an Advanced Directive _____I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

__ Living Will __ Durable Medical Power of Attorney __ 5 wishes __ DO Not Resuscitate (DNR)

Signature:_____ **Date:**_____

Patient Responsibility Form

1. The patient is responsible for providing MedNova Primary Care with the most correct, active and up to date information about their insurance prior to each visit.

2. MedNova Primary Care will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.

3. Patients are responsible for the payment of co-pays at the time of service.

4.Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.

5. MedNova Primary Care is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance.

6.In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.

7.Patients have the right to check with their insurance about coverage before receiving any service provided at MedNova Primary Care.

8.The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether our physicians participate.

9.The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.

10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

11. Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.

12. The patient agrees that in return for the services provided to them by MedNova Primary Care, they will pay their account at the time service is rendered or upon insurance claim processing. If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If copayments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to MedNova Primary Care.

Worker's Compensation and Automobile Claims

MedNova Primary Care does **not** accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding MedNova Primary Care policies regarding patient responsibilities.

Signature:_____ **Date:**_____