Cypress Houston
Family Practice

New Patient Registration Form

General Information (please print)

Name _____ DOB _____ Sex: __M __F

Social sec # _____ Marital status: Single___ Married___ Divorced ___Widowed ___

Primary address _____

City _____ State _____ Zip _____

Home phone _____Work phone _____ Cell phone _____

Emergency contact _____ Relationship _____ Phone _____

E-mail _____ Authorize E-mail?: ___Y ___N

Pharmacy name _____ Phone _____ Fax _____

Employment status: ___employed ___not employed ___retired ___student

Employer _____ Occupation _____

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _____ NO _____ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of CHFP permission to discuss my medical condition with the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Doctor Information

Referring Physician _____ Specialty _____

Primary Care Physician _____ Phone _____

Primary Insurance

Insurance Name _____ Subscriber's Name _____

Insurance ID# _____

SSN _____ DOB _____ Relationship to Insured _____

Secondary Insurance

Insurance name _____ Subscriber's Name _____

Insurance ID# _____

SSN _____ DOB _____ Relationship to insured _____

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of CHFP to enroll me in the ePrescribe Program. .

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of CHFP to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of CHFP to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of CHFP to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to CHFP the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and CHFP to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify CHFP of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by CHFP is the patient's responsibilities.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish***. I acknowledge that I have received a copy of the CHFP Notice of Privacy Practices.***

_____	_____	_____
Printed name	Signature	Date signed