PATIENT REGISTRATION

Last Name______________________________First Name ______________________________ MI ____________

Address______________________________ City/State________________________ Zip ______________________

Home Phone __________________ Cell Phone __________________ Work Phone ________________________

Physician you normally see ________________________ Physician who referred you ______________________

Date of Birth ___/___/_____ Sex: M F Marital Status______ Social Security No. ______________________

Employer:________________________________ City/State__________________ Zip ______________________

RESPONSIBLE PARTY OR INSURED (If different than patient)

Guarantor Name:____________________________________ Phone ___________________Cell_____________

Mailing Address:______________________________________City/State___________________ Zip___________

Social Security No.______________________________________Date of Birth______________________________

Employer:_______________________City/State____________Zip________ Relationship to Patient: ___________

INSURANCE INFORMATION

Primary Insurance ____Group _____________________________

Insurance Address____ Policy I.D. __________________________

Insured's Relationship to Patient __________**IF NOT SELF, FILL OUT INFORMATION FOR RESPONSIBLE PARTY ABOVE**

Secondary Insurance____Group______________________________

Insurance Address____ Policy I.D. __________________________

Insured's Name____________________________________Relationship to patient _________________________

Insured's date of birth________________ Insured's Employer____

Tertiary Insurance____ Group________________________________

Insurance Address____ Policy I.D. __________________________

Insured's Name____________________________________Relationship to patient _________________________

Insured's date of birth________________ Insured's Employer____

EMERGENCY CONTACT (Not living with patient)

Name____Relationship _________________________

Home Telephone No.______________________________Work Telephone No. ______________________________

Primary Pharmacy ________________________________City/State __________________ Zip _______________

Secondary Pharmacy ______________________________ City/State __________________ Zip _______________

Your Email: ____________________________ Can we leave a message on your home phone? Y N

Can we leave a message on your cell phone? Y N

Race:__________________ Ethnicity: Hispanic or Non-Hispanic Primary Language: __________________

(OVER)

5/2016

AUTHORIZATIONS

CONSENT FOR TREATMENT: I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

RELEASE OF INFORMATION: I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, communicable disease or non-communicable disease) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare/Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

ASSIGNMENT OF INSURANCE: I authorize any insurance benefits to be paid directly to the physicians providing services to the patient, all benefits due, and payable as a result of services rendered.

FINANCIAL RESPONSIBILITY: I understand that the physician will file claims with all insurance carriers as a courtesy. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer unless there is a specific written agreement between the physician, the patient and the payer.

MEDICARE PATIENTS: Medicare will pay only for services it determines to be "reasonable and necessary". If services that the physician has requested are denied for payment by Medicare, I agree to be personally and fully responsible for those charges.

ADVANCED DIRECTIVE: Do you have an Advanced Directive? ❑ YES ❑ NO

Would you like information regarding Advance Directives? ❑ YES ❑ NO

ACKNOWLEDGMENTS

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how the patient's medical information will be used and disclosed by NRHS is in the "Notice of Privacy Practices". A copy has been provided to me in my registration packet and is posted in the clinical site. I have received and accepted a copy of NRHS "Notice of Privacy Practices". ❑ YES ❑ NO

Reason for refusal if "NO" ____

PATIENT RIGHTS: I have received a copy of "Your Medical Treatment Rights Under Oklahoma Law" and "General Information Concerning your Rights & Responsibilities". ❑ YES ❑ NO

TELEPHONE CONSUMER PROTECTION ACT (TCPA): You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services.

I have read this disclosure and agree that I may be contacted as described above.

____ ____________________

Signature Date

Certification: I hereby certify that I have read each of the above statements, that they are true and correct to the best of my knowledge and I have had each item explained to me to my satisfaction. I further certify that I am the patient or duly authorized by the patient to accept the sign the agreement and accept its terms. A photocopy has the same effect as the original.

________________________ ____________________ ____________________

Signature of patient/Guarantor/Authorized Person Relationship Date Signed

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. PATIENT INFORMATION (PERSON WHOSE INFORMATION WILL BE SHARED)

Name ____ Date of Birth ____________________________________

Address ____ City / State / Zip ____________________________________

Area Code & Telephone Number ____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Regional Health System's owned clinics and the physicians employed within to share my protected health information for reasons in addition to those already permitted by law.

A. PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE MY INFORMATION:

(Name, Address, Phone & Fax) **Relationship** **Purpose**

____

____

____

____

B. INFORMATION TO BE SHARED:

1. CHECK ONE OR MORE OF THE BOXES BELOW:

☐Entire Medical Record (includes all records except Psychotherapy Notes)

☐Psychotherapy Notes

☐Mental Health Records	☐History and Physical	☐Operation Report(s)
☐Pathology Report	☐Consultation Report(s)	☐Discharge Summary
☐Progress Notes	☐Laboratory Report(s)	☐Radiology Report(s)
☐EKG Reports	☐Radiology Films	☐Alcohol or Drug Abuse Records
☐Physician's Orders	☐Other	

2. COVERING SERVICES BETWEEN ____________AND____________ (Insert either date(s) or "all")

IV. EXPIRATION & REVOCATION

A. THIS AUTHORIZATION WILL EXPIRE: (MUST CHOOSE ONE)

☐ 3 years after last office encounter ☐ Other (insert date or event): ______________________

B. RIGHT TO REVOKE

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. ACKNOWLEDGEMENTS

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

4. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

5. I understand Norman Regional employed physicians/advance practice nurses/physician assistants are members of Oklahoma Physician Health Exchange (OPHX), and my provider may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

6. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. SIGNATURE

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative)	**Date**
Printed Patient or Legal Representative Name	**Capacity of Legal Representative (if applicable)**

Norman Regional Health System's Owned Clinics

Blanchard Family Medicine	Neurology Associates
Diabetes & Nutrition Education	Newcastle Family Medicine
Endocrinology Associates	Norman Heart & Vascular
Family Medicine – Findlay	Family Medicine– HPX
Family Medicine – Moore	NRHS Internal Medicine Assoc P&S
Family Medicine – Noble	NRHS Journey Clinic
Family Medicine – South OKC	NRHS Surgical Associates
Family Medicine at Doctor's Park	Oklahoma Sleep Associates
Heart Plaza Imaging	Primary Care – Waterview
Infectious Disease	Primary Care – West Norman
Miles Family Medicine	Pulmonary Clinic at Medical Plaza
Moore Care for Women	Rheumatology Associates
Moore Pediatrics	The Pulmonary Clinic