SAN MATEO ORTHOPEDIC MEDICAL GROUP PATIENT REGISTRATION FORM

_____ _____ _____
Last name **First Name** **Date of Birth**

Address:_____
Street **City/State/Zip**

Home phone:_____ **Cell phone:**_____

Email: _____

Method of preferred Communication (circle one): Email Home Phone Cell Phone

Referring Doctor's Name:_____ **Primary Doctor's Name:**_____

Occupation: _____ **Employer:**_____

Medical Information can be discussed with (circle one): Patient only or Family

Member/Friend:_____

Can detailed messages regarding medical results be left on answering machine/voicemail? Yes No

How did you hear about our practice? _____

Who to call for an emergency: Name:_____ **Phone #:**_____

Relationship to patient: _____

Preferred Pharmacy Name and Address:_____

BENEFIT ASSIGNMENT & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:
I authorize the insurance companies to make payment directly to San Mateo Orthopedic Medical Group for medical services. I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles, and any other charges my insurance company deems by responsibility. In the event my account should become delinquent for a period of thirty days or more I hereby acknowledge that I will be responsible for the entire balance. *Also, I am aware I am required to cancel or reschedule an appointment with 24 hours notice, otherwise I will be charged a $30.00 fee. Procedures may be canceled or rescheduled with a 72-hour notice, otherwise I will be charged a $75.00 fee.*

Signature:_____ **Date:**_____

RELEASE OF MEDICAL RECORDS:
I hereby authorize the release of my information, verbal, and written, contained in my medical record to my insurance company and related healthcare providers as it relates to my treatment. In addition, I hereby authorize this medical office to obtain medical records and/or professional information from any other medical professional as it relates to my treatment. A HIPAA authorization form **gives covered entities permission to use protected health information for purposes other than treatment, payment, or health care operations."Consent" is a general term under the Privacy Rule, but "authorization" has much more specific requirements**. The Privacy Rule permits, but does not require, a CE to obtain patient "consent" for uses and disclosures of PHI for treatment, payment, and healthcare operations.

Signature:_____ **Date:**_____

DISCLOSURE NOTICES:
I acknowledge I have read a copy of the DISCLOSURE NOTICE and have received a copy of this office's Notice of Privacy Practice. Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California. 800.633.2322 (www.mbc.gov)

Signature:_____ **Date:**_____