STAPP MEDICAL GROUP, LLC

REGISTRATION FORM

Today's date: | Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

How did you hear about us (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Google ❑ Other

Email address: Would you like to be added to newsletter? ❑Yes ❑No

Ethnicity: ❑ Non-Hispanic ❑ Hispanic ❑ Other

Race: ❑ African American/ Black ❑ Caucasian/ White ❑ Native American ❑ Asian ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Primary Insurance coverage:

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative : | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stapp Medical Group, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _Date_

****Please provide us with your**

email address:____

STAPP MEDICAL GROUP HIPAA POLICY
USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Stapp Medical Group will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge that Stapp Medical Group may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Stapp Medical Group may disclose my medical information to a *Business Associate* for the same reasons, and that the *Business Associate* will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Acknowledged and agreed to by:

Patient: ____________________________ **or Representative:** _________________________

Signature: _______________________________ **Date:** _________________________________

The Federal Government now restricts this office and Stapp Medical Group form discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Stapp Medical Group permission to discuss my protected medical information with the following individuals:

_____________________________________ ____

Name Relationship

_____________________________________ ____

Name Relationship

Signature of Patient: ______________________________________ **Date** ______________________

Please list daytime telephone number at which you prefer to be reached. ________________________

Can we leave a message regarding your protected health information at the number you have provided? Yes No

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________
Printed Name of Patient or Personal Representative	**Relationship to Patient**
______________________________	______________________
Printed Name of Witness	**Employee Job Title**
______________________________	______________________
Signature of Witness	**Date**