Northwest Physicians Group

Patient Registration Form

Patient information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other	Preferred Language

Race (check all that apply) ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity (check all that apply) ❑ Hispanic or Latino ❑ Multiple ❑ Not Hispanic or Latino ❑ Patient Declined

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Email Address	Primary Physician

Responsible Party/Parent/Guardian (circle one) Check if same as [ ] Patient

Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?

Mailing Address	Apt/Lot	City/State	Zip code	Phone #s: Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City/State	Zip code

Insurance Information Check if [ ] Self pay

Primary insurance: Check if same as: [ ] Responsible Party		**Secondary insurance:** Check if same as: [ ] Responsible Party	
Insurance Name	Begin date	Insurance Name	Begin date
Subscriber/Member Name	Date of Birth	Subscriber/Member Name	Date of Birth
What is Patient's Relationship to Subscriber?	Gender (circle) M / F	What is Patient's Relationship to Subscriber?	Gender (circle) M / F
Insurance Mailing Address City/State Zip code		Insurance Mailing Address City/State Zip code	
Subscriber/Member #	Group #	Subscriber/Member #	Group #

Patient Portal

To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.

Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.

To opt out of the patient portal please check one of the options below:

_____ I am not interested in signing up for the portal at this time _____ I do not have an e-mail address

_____ _____

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print

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NOTICE of PRIVACY PRACTICES

A copy of ***Facility's*** HIPAA Notice of Privacy Practices are posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information ("PHI").

DISCLOSURE of PROTECTED HEALTH INFORMATION and EMERGENCY CONTACT

I authorize ***Facility*** to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I list them by name below.

Name: _____ **Relationship** _____

Name: _____ **Relationship**_____

I authorize ***Facility*** to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ☐ Yes ☐ No

Emergency Contact: _____ **Phone number**_____ **Relationship:** _____

FINANCIAL POLICY and AUTHORIZATION for ASSIGNMENT of BENEFITS

Facility strives to make our financial policy, insurance filing, and billing process for our patients as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 50% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. ***Facility*** will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to ***Facility*** of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize ***facility*** to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT for EXAMINATION and TREATMENT

I hereby consent and authorize ***Facility*** to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of ***Facility***. Any photographs or other images taken will become part of my medical record. ***Facility*** will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that ***Facility*** will provide me with information and forms prior to such procedures. . I grant ***Facility*** consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize ***facility*** to search for and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying ***facility***.

_____ _____

Patient's Name (Please Print) Signature & Date

_____ _____

Patient Representative (If patient is unable to sign) Signature & Date

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Appointment Policy: No-Shows & Late Cancellations

We want to make it easy for you to get the care you need. When appointments are missed or canceled late, other patients lose the chance to be seen. Please help us keep access open for everyone:

- **Cancel or reschedule at least 48 hours in advance.**
- **Arrive 20 minutes early** to check in. If you're running late, call us— late arrivals may need to be rescheduled.
- **Reminder messages:** We'll send appointment reminders when possible. Make sure your phone/email is up to date.
- **Repeated missed appointments:** Multiple missed visits (3 or more missed appointments) in 12 months disrupts our ability to provide care to you and others waiting for care and can result in dismissal from our practice.

Please sign below that you have been informed of the information outlined above regarding our No-show and late cancellation policy.

Patient Name: _____

Patient Signature: _____

Patient MRN: _____

Date: _____

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Date: _____Name:_____DOB:_____Age:_____Male/Female

Problem/Reason for Visit: _____ Any prior testing for this problem: _____

_____ _____

_____ _____

Current Medication(s (include over the counter, vitamins, supplements or herbal medications):

☐ No Home Medications ☐ See Attached List

_____

_____

_____

_____

Allergies: ☐ None ☐ Penicillin ☐ Iodine/Shellfish

Other: _____

Pharmacy: _____ Height: _____Feet: _____Inches Weight: _____lb

Previous Primary Care Physician: _____

Surgeries: ☐ None ☐ Anesthesia Complications? _____

_____

_____

Current Tobacco Use: ☐ Yes ☐ No ☐ Chewing Tobacco/Snuff ☐ Second Hand Smoke Exposure

# of years:_____ # packs/day:_____ ☐ Former Smoker Quit (year): _____

Current Alcohol Use: ☐ Yes ☐ No ☐ Past How often do you drink alcohol? _____

Substance Abuse: ☐ Yes ☐ No ☐ Past Type? _____

Occupation: _____ Disabilities: _____ ☐ Visual Disabilities

☐ Pregnant/Considering Pregnancy ☐ Metal in body or exposure to metal ☐ Glaucoma ☐ Are you claustrophobic?

Family Health History: ☐ No problems ☐ Anesthesia Complications ☐ Malignant Hyperthermia

How is the health of your immediate family? List conditions:

Mother: _____ ☐ deceased

Father: _____ ☐ deceased

Sister: _____ ☐ deceased

Brother: _____ ☐ deceased