BERKELEY FAMILY PRACTICE

Patient Registration Form

First Name: _____ **Last Name**: _____ **MI**: _____ **Prefix**: Mr. Mrs. Miss Ms. Dr. Rev. **Sex:** Male Female Other

Date of Birth: ___/___/____ **Social Security #:** ____-___-____**Marital Status:** ___Single___Married ___Divorced ___Widowed___Other

Home Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Mailing Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Email: _____**Home #:** _____-_____-_____**Cell #:** _____-_____-_____**Work #:**_____-_____-_____

Race/Ethnic Group: ____African American ____Caucasian ____ Hispanic ____ Other **Language:** ____ English ____ Spanish ____ Other

Patient's Employer: _____**Part Time:** _____ **Full Time:** _____

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYING BILL)

First Name: _____ **Last Name**: _____ **MI**: ____ **Guar. Birth Date:** ___/___/____ **Guar. Social Security #:** ____-___-____

Guar. Address: _____**City:** _____**State:** _____ **Zip Code:** _____

Guar. Home #: _____-_____-_____**Cell #:**_____-_____-_____**Work #:**_____-_____-_____**Guar. Employer:**_____

PATIENT'S INSURANCE INFORMATION

Primary Coverage:

Insured Name:
_____

Date of Birth: _____/_____/_____

Employer:
_____

Insurance Co. Name:
_____

ID#:
_____

Group #:
_____

Insurance Co. Phone #: _____-_____-_____

Patient's Relation to Insured: ___ Self ___Spouse ___Child ___Other

Secondary Coverage:

Insured Name:
_____

Date of Birth: _____/_____/_____

Employer:
_____

Insurance Co. Name:
_____

ID#:
_____

Group #:
_____

Insurance Co. Phone #: _____-_____-_____

Patient's Relation to Insured: ___ Self ___Spouse ___Child ___Other

EMERGENCY CONTACT INFORMATION

In case of an emergency, please contact: _____

Relation to patient: _____ **Home #:** _____-_____-_____ **Cell #:** _____-_____-_____ **Work #:**_____-_____-_____

PHARMACY INFORMATION

Pharmacy Name: _____ **Pharm. Phone #:** _____-_____-_____ **Pharm. Fax #:** _____-_____-_____

Pharm. Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

E-PRESCRIPTON PATIENT CONSENT

Our office is now offering E-prescriptions, which are computer generated prescriptions created by your provider and sent directly to your pharmacy. There are many benefits of E-prescriptions, such as your prescriptions arriving at your pharmacy before you leave the office, you don't have to make an extra trip to drop off prescription at the pharmacy, your pharmacy notifies you when you need refills, and there is no handwriting for the pharmacist to interpret as everything is done electronically. For the benefit of your healthcare, we ask to be allowed to access your prescription history. What this does is allows us to access pharmacy's database and see your prescription history and what you are currently being prescribed by us and other providers.

_____ **YES,** I give permission for BFP to access my prescription history
_____ **NO,** I do NOT give permission for BFP to access my prescription history

Print Name: _____ Signature: _____ Date: _____/_____/_____

RELEASE OF MEDICAL INFORMATION

I authorize Berkeley Family Practice and other physicians involved in my medical care to release protected health information in my record to each other as allowed by law. This includes: office notes, labs, operative reports, imaging reports, insurance/billing information and medication list. I also authorize my doctors and providers to communicate with each other by phone, fax, mail or any means that they feel is necessary to optimize my medical care. I understand this information may be shared for the purposes of my treatment, obtaining payment, obtaining insurance authorizations, audits, and other necessary health care operations. Any other use of disclosure of my information requires my specific written authorization and is not allowed without such written authorization. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I, _____ DOB: _____, give my consent for the staff of Berkeley Family Practice to be able to release **any of my medical information** to:

1. Name: _____ Relation: _____ Phone #: _____-_____-_____
2. Name: _____ Relation: _____ Phone #: _____-_____-_____
3. Name: _____ Relation: _____ Phone #: _____-_____-_____

_____ I do not want my information released to **anyone**.
_____ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

MISSED OFF APPOINTMENT AND PROCEDURE POLICY

Missed office appointments and late cancellations prevent other patients' access of care. It is therefore our policy to bill for missed appointments. You should be aware that your insurance company will NOT pay for these cancellations fees and you will be responsible for the entire amount before you will be seen at your next visit. Contact our office as soon as possible regarding any cancellations. Missed appointment or cancellation without a **24 hour notice** can be charged up to a **$25.00** fee. Medicaid patients can be discharged for multiple occurrences.

MEDICAL FORM COMPLETION

There will be a **$25.00** fee for completing any medical forms or special letters for insurance companies (other than health claims for our services), disability clams, FMLA, or similar forms. You will be responsible for these charges, should they occur. Also, an appointment will be needed to have forms completed.

DEDUCTIBLES AND COPAYS

I understand that my deductible and copay are due at the time of treatment.
I am responsible for any unpaid balances and additional collection fees.

I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE AND BY SIGNING BELOW, ACKNOWLEDGE RECIEPT AND UNDERSTANDING OF THE SAME.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____