# NEW PATIENT REGISTRATION

**Primary Doctor at Stillwater Family Care:** ______________________________

**Preferred Pharmacy:** ______________________________

**Last Name** ____________ **First Name** ____________ **Middle** ____________

**Street Address** ____________ **Apt** ________ **City** ____________

**State** ________ **Zip** ________ **Home Phone** (     ) ____________ **Cell Phone** (     ) ____________

**Social Security #** ____________ **Date of Birth** ____________ **Age** ______ **Sex: (Circle):** Male / Female

**Marital Status:** ________ **Language:** ________ **Race:** ________ **Ethnicity:** ________

**Email Address:** ______________________ **Employer** ____________

**Guarantor Information: (*whom statements are sent)**

**Guarantor Name:** ______________________ **Guarantor Date of Birth:** ____________

**Guarantor Social Security #:** ____________ **Guarantor phone:** ____________

**Guarantor Email Address:** ______________________ **Relationship to patient:** ____________

**Guarantor Address:** ______________________ **City:** ____________ **State:** ______ **Zip:** ______

**EMERGENCY CONTACT OR IF PATIENT IS A MINOR**

**Next of Kin/Parent or Guardian (different from Guarantor)**

**Last Name** ____________ **First Name** ____________ **Middle** ____________

**Date of Birth:** ______________________ **Relationship to Patient** ____________

**Street Address** ______________________ **Apt** ________ **City** ____________

**State** ________ **Zip** ________ **Home Phone:** (     ) ____________ **Cell Phone** (     ) ____________

**INSURANCE INFORMATION**

**Primary Insurance** ______________________ **Insured Party:** Self Spouse Parent Other

**Policy Holder's Name:** ______________________ **SSN:** ____________ **DOB:** ____________

**Policy Holder's Place of Employment:** ______________________ **Work Phone Number:** (     ) ____________

**Insured ID#** ____________ **Group #** ____________ **Insurance Phone # :** (     ) ____________

**Secondary Insurance** ______________________ **Insured Party:** Self Spouse Parent Other

**Policy Holder's Name** ______________________ **SSN:** ____________ **DOB:** ____________

**Policy Holder's Place of Employment:** ______________________ **Work Phone:** ____________

**Insured ID#** ____________ **Group #** ____________ **Insurance Phone #:** (     ) ____________

**To the best of my knowledge the above information is complete and accurate.**

**Signature Patient/Guarantor/Guardian** ______________________ **Date** ____________

# Stillwater Family Care Office Policies

Patient Name:_______________________________ Date Of Birth:________________

Primary Care Provider:___________________________________

## Payment Policy

I understand that all co-payments, coinsurance, and deductible will be required to be paid in full upon check in for your appointment. Payment in full for all expenses incurred at your visit regardless of insurance may be required at the time of serviceFor your convenience Stillwater Family Care takes personal checks, Visa/MasterCard/American Express and cash. Any medical insurance which you may have that is intended to protect you against financial loss and payment in full for your care is ultimately your responsibility regardless of coverage. Stillwater Family Care files with insurance as a courtesy service only.

I understand it is my responsibility to provide Stillwater Family Care with up-to-date insurance information as well as any information requested to enable Stillwater Family Care to file a healthcare claim on my behalf for services rendered. **Up-to-date insurance information is due upon check in. If up to date insurance information is not provided upon check in, I may be responsible for payment in full.** I also understand that it is ultimately my responsibility to know my insurance policy coverage and benefits. I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party and I will make sure that my claims are paid promptly. If at any time insurance revokes payment for services rendered, I understand I would be responsible for payment.

## Assignment of Benefits:

By signing below, I authorize Stillwater Family Care to verify insurance coverage, submit medical claims and receive payment on my behalf for medical care provided.

## Treatment Authorization:

I certify that I am the patient or duly authorized general agent of the patient. I authorize Stillwater Family Care staff and physicians to provide medical care.

## No Show Appointment Policy:

I understand that Stillwater Family Care requires a minimum of 1 hour notice to cancel or reschedule appointment. If I fail to give sufficient notice, I may be subject to a $35.00 no show fee which will be charged to my account. I also understand that if I have multiple no showed appointments my care at SFC could be terminated.

## Consent to Call/Text

I authorize Stillwater Family Care to send text message or automated phone call reminders regarding my future or missed appointments, account balances, and other notifications to me to the phone number provided. I may specify what communication method I prefer at any time by notifying a front office staff team member of Stillwater Family Care. I understand that If I receive text messages charges from my cell phone provider may apply.

By signing this document, I am indicating I understand and consent to all the above.

Signature: ______________________________________________ Date Signed: ________________________

## Prescription History

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

| Patient Name | Date of Birth | |
|---|---|---|
| | | |

| Patient Address |
|---|
| |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **CA** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Stilwater Family Care uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized for your care.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Stillwater Family Care.
3. I have the right to revoke this authorization at any time by writing to Stillwater Family Care. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization has no expiration while you are an you are an active patient of a Stillwater Family Care provider.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE SFC Providers nor staff members TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

| Signature of patient or representative authorized by law | Date |
|---|---|
| | |

# Stillwater Family Care Office Policies

**Patient Name:**_______________________________ Date Of Birth:________________

**Primary Care Provider:**___________________________________

## Payment Policy

I understand that all co-payments, coinsurance, and deductible will be required to be paid in full upon check in for your appointment. Payment in full for all expenses incurred at your visit regardless of insurance may be required at the time of serviceFor your convenience Stillwater Family Care takes personal checks, Visa/MasterCard/American Express and cash. Any medical insurance which you may have that is intended to protect you against financial loss and payment in full for your care is ultimately your responsibility regardless of coverage. Stillwater Family Care files with insurance as a courtesy service only.

I understand it is my responsibility to provide Stillwater Family Care with up-to-date insurance information as well as any information requested to enable Stillwater Family Care to file a healthcare claim on my behalf for services rendered. **Up-to-date insurance information is due upon check in. If up to date insurance information is not provided upon check in, I may be responsible for payment in full.** I also understand that it is ultimately my responsibility to know my insurance policy coverage and benefits. I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party and I will make sure that my claims are paid promptly. If at any time insurance revokes payment for services rendered, I understand I would be responsible for payment.

## Assignment of Benefits:

By signing below, I authorize Stillwater Family Care to verify insurance coverage, submit medical claims and receive payment on my behalf for medical care provided.

## Treatment Authorization:

I certify that I am the patient or duly authorized general agent of the patient. I authorize Stillwater Family Care staff and physicians to provide medical care.

## No Show Appointment Policy:

I understand that Stillwater Family Care requires a minimum of 1 hour notice to cancel or reschedule appointment. If I fail to give sufficient notice, I may be subject to a $35.00 no show fee which will be charged to my account. I also understand that if I have multiple no showed appointments my care at SFC could be terminated.

## Consent to Call/Text

I authorize Stillwater Family Care to send text message or automated phone call reminders regarding my future or missed appointments, account balances, and other notifications to me to the phone number provided. I may specify what communication method I prefer at any time by notifying a front office staff team member of Stillwater Family Care. I understand that If I receive text messages charges from my cell phone provider may apply.

By signing this document, I am indicating I understand and consent to all the above.

Signature: ____________________________________________ Date Signed: ________________________

# Hipaa Consent

**Patient Name:**_______________________________ **Patient Date of Birth:**_________________________

**Primary Care Provider:**______________________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Stillwater Family Care originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals w ho contribute to my care a source of information for applying my diagnosis and treatment information to my bill
- A means for a third-party payer to verify that services were billed as actually provided
- A means for a third-party payer to verify that services were billed as actually provided

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Stillwater Family C are reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, healthcare operations and that Stillwater Family Care is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing: except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law, we are required to notify you that: the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

In addition to the release outlined above, information may be released to the following individuals or organizations for the indicated purpose: (this would include anyone who may be allowed to make appointments, pick up prescriptions, etc. for the patient)

Name:____________________________ Name:____________________________

Relationship:______________________ Relationship:______________________

Phone #:__________________________ Phone #:_________________________

I request the following restrictions to the use and/or disclosure of my health information:

______________________________________________________________________________

Please check one: ___ Yes ____ No – You may/may not leave a message for appointment reminders or medical information on my voicemail or messaging service.

"In our continuing efforts to improve the care yo u receive, the Providers in this facility have partnered w ith MyHealth Access Network. This provides us w ith the informa tion we need to give you care in a timely & cost efficient manner. If you have any questions, please ask our staff. Or visit MyHealth at, www.myhealthaccess.net & click on the "for patients" link in the center of the page."

Signature of Patient/Legal Representative (if other) Effective Date (Today'sDate)

______________________________________ ____________________