South Mountain Family Practice
9 Saint Paul Street
Boonsboro, MD 21713

Patient Registration

Please print clearly and complete all information so that your claims can be processed quickly and efficiently.

Name _____ Social Security #_____

Date of birth_____ Sex _____ Marital Status S___ M ___ W ___ D ___

Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Employer_____

May we call you at work? Yes ___ No ___

May we leave a detailed message on your home answering machine? Yes ___ No ___

Insurance and Responsible Party Information

Primary Insurance _____ Phone _____

Address, City, Zip _____

Policy ID# _____ Group # _____

Policyholder's Name _____ Relationship to Patient _____

Policyholder's Employer _____ Phone _____

Policyholder's social security # _____ Policyholder's date of birth _____

Secondary Insurance _____ Phone _____

Policy ID# _____ Group # _____

Policyholder's Name _____ Relationship to patient _____

Policyholder's Employer _____ Phone _____

Policyholder's social security # _____ Policyholder's date of birth _____

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Release of Information

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize South Mountain Family Practice to release my information in the course of my examination or treatment to the following designated person(s):

Name: _____Phone _____Relationship _____

Name: _____Phone _____Relationship _____

Patient's Signature: _____ Date: _____

Benefit Assignment

I hereby give permission to South Mountain Family Practice to examine and treat me. I also assign transfer and set over South Mountain Family Practice or their physicians all of the medical reimbursement benefits under my insurance policy. I also authorize the release of any and all medical information and records to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorizations. I understand that I am financially responsible for all charges and agree to promptly pay all charges when billed and accept legal responsibility for any and all charges for the patient named.

Patient's Signature _____ Date: _____

Patient Name: _____ Date of birth: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully. A copy will be provided upon request.

Your Health Information Rights

- Although your health record is the physical property of the Medical Practice that compiled it, the information belongs to you.
- You have the right to inspect or obtain a copy of your health record (except where restricted by law) upon your written request.
- You have the right to request an amendment of information in your health record that you believe is incorrect or incomplete. Any request for amendments to health information must provide the reason for the amendment.
- You have the right to request a restriction on certain uses and disclosures of your information; however, we are not required to agree to a requested restriction.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by mail.
- You have a right to revoke your authorization to use or disclose health information except to the extent that action has already been taken. Any request must be made in writing.

Our Responsibilities

This practice is required to:

- Maintain the privacy of your health information.
- Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have made to communicate health information by alternative means to alternative locations.
- We will not use or disclose your health information without your authorization, except as described in the full copy of this notice.

_____ _____

Signature of patient or legal representative Date

_____ _____

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY!

- I authorize the release of all medical records to the referring physicians and to my insurance company, if applicable.
- I allow fax transmittal of any medical records, if necessary.
- I understand that payments of charges incurred, co-pays, co-insurance, deductibles, and non-covered services are DUE AT THE TIME OF SERVICE unless other definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collections costs in the event of defaults of payment of my charges.
- I understand there will be a $30.00 service fee for returned checks.
- I understand that appointments not cancelled within one business day of the scheduled appointment will be charged $35.00 due at the time of your next visit.
- I acknowledge full financial responsibility at the time services are rendered for care not authorized by my HMO/POS plan. Our office requires 48 hours to process all insurance referral requests.
- I accept full financial responsibility if incorrect insurance information is provided that results in a denial of the insurance claim.
- I understand the staff will assist in dealing with my insurance company, but it is my responsibility to know and understand my own insurance company guidelines.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____ Date of Birth: _____

We appreciate the confidence that you have expressed in selecting us as your physician. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstandings at a later date. If you have any questions about our services, fees, or other aspects of your care please feel free to discuss your concerns with our office manager @ 301-432-0623.