



Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date: _____ Thank you for selecting ProHEALTH Care Associates.

PATIENT INFORMATION

Patient's Last Name:		First:	Middle:	Gender:	Age:	Birth Date:
Marital Status: S M D W SEP		Preferred Language:			Student: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Answer		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to Answer		
Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone No.:	
Mobile Phone No.:		Email Address:		Work No.:		
Name of Employer:		Address:	City/Town:	State:	Zip Code:	

SPOUSE'S INFORMATION

Last Name:		First:	Middle:	Gender:	Age:	Birth Date:
Mobile Phone No.:		Work No.:				
Employer:	Street Address:	City/Town:	State:	Zip Code:		

PARENT INFORMATION

Complete the section below with your parent's information if you are a full time student covered under their health insurance.

Insured's Last Name:		Insured's First:	Middle:	Gender:	Age:	Birth Date:
Mobile Phone No.:		Work No.:				
Employer:	Street Address:	City/Town:	State:	Zip Code:		

EMERGENCY CONTACT

Name:		Relationship to Patient:				
Primary Telephone No.:			Secondary Telephone No.:			

PRIMARY CARE PHYSICIAN

REFERRING PHYSICIAN

Primary Care Physician Name:		Referring Physician (if not same as PCP):				
Street Address:		Street Address:				
City, State, Zip:	Telephone No.:	City, State, Zip:			Telephone No.:	

Please provide the name/s and telephone numbers of any other doctors treating you at this time.

PHARMACY INFORMATION

Name of Pharmacy:		Address:	Telephone No.:	Fax No.:
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HEALTH INSURANCE INFORMATION

Patient's Relationship to Insured: Self Spouse Child Other:

PRIMARY INSURANCE	Insurance Name:	Claims Address:	Telephone No.:	Group No.:
				ID No.:
	Insured's Name (if not self, spouse or parent listed above):			Birth Date:

Patient's Relationship to Insured: Self Spouse Child Other:

SECONDARY INSURANCE	Insurance Name:	Claims Address:	Telephone No.:	Group No.:
				ID No.:
	Insured's Name (if not self, spouse or parent listed above):			Birth Date:

WORKER'S COMPENSATION INFORMATION

Is the reason for this visit due to a work related accident? Yes No If yes, you must complete this section.

Date of Injury/Onset of Illness:	Employers Insurance Carrier Name & Address:
WCB Case No.:	Carrier Case No.:
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Day Worked:
Briefly describe how and where patient's injury occurred:	

NO FAULT INFORMATION

Is the reason for this visit due to a motor vehicle accident? Yes No If yes, you must complete this section.

Date of Accident:	Insurance Carrier Name:	Address:
Policyholder's Name:	Policy No.:	Claim No.:
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	Claims Adjuster:	Telephone No.:
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Day Worked:	
Briefly describe how and where patient's injury occurred:		

ATTORNEY INFORMATION

Law Firm Name:	Address:	Name of Attorney Handling Case:	Telephone No.:
			Fax No.:

PATIENT SIGNATURE: _____

DATE: ____/____/____



PATIENT NAME _____

DATE OF BIRTH: _____/_____/_____

ProHEALTH Care Associates, LLP

GENERAL CONSENT

Consent for Medical Treatment. I give consent to ProHEALTH Care Associates, LLP, its staff, physicians and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

Authorization of Payment of Insurance Benefits. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

Signature on File (applies to Medicare patients only). I certify that the information given by me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Financial Agreement. I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer at the time of service, HMO or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I agree to pay all bills when presented. I understand that there will be a \$25.00 charge for all returned checks.

Release of Information. I understand that the Practice will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice's charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of the Practice or a third party payor; (5) for the Practice's normal health care operations. I understand that the Practice may communicate information including protected health information with me through text or email, and through the Practice's electronic health record system.

I understand that to ensure continuity of care, all ProHEALTH providers will have access to the information in my electronic health record.

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

I understand that the Practice may access information from any pharmacy from which I have filled prescriptions. This includes prescriptions for medicines to treat AIDS/HIV, mental health illness, substance abuse, and STDs, if applicable. I further understand that this information will become a permanent part of my medical record.

Acknowledgement of Receipt of the Privacy Notice. I have received a copy of the Practice's Privacy Notice, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this General Consent form.



SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

IF SIGNED BY A LEGAL REPRESENTATIVE (PRINT NAME) RELATIONSHIP TO PATIENT

IMPORTANT NOTICE

In order to address changes in the Federal law, ProHEALTH has revised its HIPAA Privacy Notice and General Consent form to address issues such as messages on answering machines, discussions with your family and friends, and email transmissions of your patient information. You may obtain a copy of the revised Privacy Notice from the front desk staff. Please review these documents closely and let us know if you have any questions.

ANY PREVIOUS RESTRICTIONS REGARDING YOUR INFORMATION THAT YOU MAY HAVE MADE WILL NO LONGER BE VALID. If you wish to request any restrictions on ProHEALTH's use or disclosure of your information, you must make your request in writing to the practice manager. We will let you know within fourteen (14) days whether or not we can accept the restriction. If we are able to accept the restriction, it will go into effect as soon as we notify you.

We take the confidentiality of your information very seriously and strive to ensure appropriate safeguards are in place at all times.

Please sign below to acknowledge that you have received this form and understand its contents.



SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

IF SIGNED BY A LEGAL REPRESENTATIVE (PRINT NAME) RELATIONSHIP TO PATIENT

