Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems ☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder ☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ Anemia ☐ Blood Disease ☐ Epilepsy ☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma ☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Arthritis ☐ Cancer ☐ Gout ☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems ☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Randy Karu M.D.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company and/or my secondary insurance company be made directly to Randy Karu M.D. for services furnished to me or my dependent . I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize this facility to disclose any and all written information from my insurance company and/or its designated representatives. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.

2. I agree to participate and assist its designated representatives with any appeal process necessary to collect payments for services rendered.

3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.

4. I understand that this assignment and authorization is subject to revocation at anytime. In any event, this authorization will expire in one year of the signature date.

5. This facility can assume no responsibility for guaranteeing payment of any charges by the insurance company(s).

6. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.

Print Name:_____

Signature:_____

Date:_____

Staff INITIAL: Date:_____

Randy Karu M.D.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices effective 1/1/2017.

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of the Notice of Privacy Practices.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

Staff Initial: _____ Title: _____

HIPAA Right of Access Form for Family/ Friend

I, _____, direct my health care and medical services providers to disclose and release my protected health information described below to:

Name _____ Relationship _____

Contact Information _____

Name _____ Relationship _____

Contact Information _____

Health Information to be disclosed upon the request of the person named above:

___ Disclose my complete health record, lab tests, prognosis, treatment, and billing for all conditions **OR**

___ Disclose only the health information listed below:

_____

This authorization shall be effective until:

___ All past, present, and future periods **OR**

___ Date _____

Name of person giving this Authorization_____

Date of Birth _____

Signature of person giving this Authorization_____

Date_____

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
  - File a complaint with your provider or health insurer, or
  - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.