Coddington Medical Family Practice, LLC

Patient Registration Today's Date:

Is your visit related to either?

Motor Vehicle Accident	Yes/No
Worker's Comp Injury	Yes/No

SSN #: - -

Gender: M/F Date of Birth:

First: MI: Last:

Nick Name: Marital Status: Single Married Separated Divorced Widowed

Race (circle one): White Black Hispanic AM. Indian/Eskimo Asian/Pacific Isalander Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Preferred Language (Circle One): English Spanish Other

Street Address: Apt:

City: State: Zip Code:

Home Phone: Cell Phone:

Person Responsible for Bill/Balance on Account:

May we add you to our Patient Portal? (***SSN # and Email REQUIRED***) Yes / No Email:

Work Phone: Employer:

Emergency Contact(s) name, phone & relationship to patient. Is it okay to release information to them? **MUST BE OVER 19** (Circle One) Yes or No

Any other person(s) to relase your information too? Yes of No (List name, phone & relationship) **MUST BE OVER 19**

Policy Holder

Name: Relationship to Patient:

Address: Date of Birth:

City: State: Zip: SSN #: - -

Employer: Phone: Home Phone:

Medicare Patients Only

Yes	No	
___	_____	1) Are you entitled to Black Lung Benefits or VA Service Card?
___	_____	2) Is your visit due to an accident? If so, did the accident happpen ___at work, ___at home, ___auto?
___	_____	3) Are you covered under group health insurance?
___	_____	4) Are you employed? If not, retirement date:_____
___	_____	5) Is your spouse employed? If not, their retirement date:_____
___	_____	6) Reason you are eligible for medicare:___age 65 or over, ___disabled, ___end stage renal disease.

I authorize direct payment of medical benefits and/or private insurance benefits on my behalf for any services furnished to me by Coddington Medical Family Practice, LLC to be submitted directly to their office. I authorize the release of any medical information necessary to coordinate care with other physicians and to process claims. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.** This may include but is not limited to outside lab testing and/or radiology services. It is necessary for our patients to take responsibility for checking with their insurance company for specific plan benefits and/or eligibility.

I hereby authorize Coddington Medical Family Practice, LLC providers or staff to leave information regarding my Protected Health Information (PHI) or my Treatment, Payment, or Operation Information (TPO) on my answering machine or voicemail. (Circle One) **Yes** or **No**.

I have been given information to read and review about the Health Insurance Portability and Accountability Act (HIPAA) which notifies me about protecting the privacy of my health information.

I have read this information thoroughly and understand it.

Patient Signature:_____ **Date:**_____

(Parent, Legal Guardian if minor, or Representative)

CONSENT TO CLINIC AND MEDICAL TREATMENT

MEDICAL CONSENT: I, knowing that I, have a condition requiring clinic or medical care, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by my physician, his/her designees, including clinic personnel, as is determined necessary in his/her judgment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the Coddington Medical Family Practice, LLC. This Consent is designated to cover all procedures in the clinic which do not require a specific consent form.

NARCOTICS, DRUGS OR MEDICINES: My use of any narcotics, drugs or medicines will be subject to clinic control, and I agree that all such narcotics, drugs or medicines will be kept in the clinic's possession to be dispensed in accordance with the clinic's rules or regulations.

PRESERVATION OF TISSUE:I hereby authorize Coddington Medical Family Practice, LLC to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during my clinic procedure.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize Coddington Medical Family Practice, LLC to furnish to the insurance carrier(s) or their agents identified on the fact sheet attached to this form such information as it or they might need to request concerning my present treatment in the clinic. I also authorize Coddington Medical Family Practice, LLC to provide my insurance carrier with verbal/written communication, reports or other data prepared by the Utilization Review Committee personnel concerning my present treatment. I further authorize Coddington Medical Family Practice, LLC to advise my insurance carrier(s) if and when it is determined by the Utilization Review Committee that I no longer require acute care. I agree to the transfer of medical information to the health care provider(s) or facility that will provide continuation of my health care. A photocopy of this authorization shall be considered as valid as the original.

ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment directly to the Coddington Medical Family Practice, LLC clinic any insurance benefits relative to this service. I also understand I am responsible for any amount not covered or paid by my insurance benefits authorized by this assignment.

CONFIDENTIALITY: I understand that the clinic will endeavor to protect the confidentiality of medical record, however, the clinic shall not be liable by reason of said records or any part thereof when responding to good faith to an apparent valid request. I also understand that I may review and copy my medical records at my own expense and that this review shall take place in the Medical Records Department during regular business hours.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS

Patient Signature:_____ **Date:**_____

If the patient is unable to consent or is a minor, please complete the following:

State the reason patient is unable to consent:_____

Signature of Parent, Legal Guardian, Authorized Representative:_____

Relationship to Patient:_____

Clinical Personnel Witness:_____

Welcome!

We're glad to have you.

Some policies to know while at Coddington Medical Family Practice:

1. **Copays** are due at the time of service.
2. You are **responsible** for what insurance, including Medicare and/or Medicaid, does not cover from your visit. This may include (but not limited to): lab work (LabCorp/Pathology Medical Services), x-rays (AMI/Radiology Associates), and anything that may require a separate charge.
3. If you have an overdue balance **greater than 60 days**, you will need to pay 10% of your past due balance prior to being seen by the provider. Forms of payment are **cash, debit or credit card(s), NO CHECKS** will be accepted.
4. Accounts in **Collections** need to be paid in full before seeing a provider, and before any medication refills. Forms of payment are **cash, debit or credit card(s), NO CHECKS** will be accepted.
5. Patients receiving schedule 2 medications are required **BY LAW** to be seen every **THREE MONTHS**. If your account balance is **greater than 60 days** past due you will be required to pay 10% of past due balance and prepay for your office visit, lab work or other services with **cash, debit or credit card(s),** but **NO CHECKS**, at the time of service.
6. No-Calls/No-Shows:
    - 2nd No-Call/No-Show: You may receive a phone call and/or a letter.
    - 3rd No-Call/No-Show: You may receive a letter, and will be considered for **possible termination** from the clinic by the provider's discretion.
7. We always welcome walk-ins, however, an appointment is not **guaranteed** the same day, we **strongly recommend** making an appointment first.
8. If you are **more than** 10 minutes late for your appointment you may be asked to:
    - See a different provider
    - Or reschedule (at the provider's discretion)
9. Please be **kind and courteous** to staff and others around you. Be respectful of phone calls, conversations, and personal space.
10. In the event that a check would be returned to us for insufficient funds (NSF) a **$40 return fee** will be added to your account.
11. Please fill out all forms and documentation to the best of your knowledge and ability. If you need **assistance** from the staff at any point please feel free to ask.

Initial_____ Date_____

Coddington Medical Family Practice

Today's Date: _____

Name: _____ Date of Birth: _____

Reason for Visit: _____

Preferred Pharmacy: _____

Past Medical History: (If you need more paper ask Front Desk)

Medications: (Any Prescriptions, also Birth Control, Herbals, Vitamins, Supplements, and Over the Counters)

Name	Dosage	Frequency

Allergies: (Medications and/or Environmental)

Name	Reaction

Surgical History:

Surgery	Date

Heath Care Maintenance/Screenings:

	Date
Colonoscopy	/ /
Mammogram	/ /
Pap Smear	/ /
DEXA/Bone Density	/ /
Stress Test	/ /
Prostate Exam	/ /
Eye Exam	/ /
Diabetic Foot Exam	/ /
Depression Screening	/ /
Alcohol Screening	/ /

Immunization: (Provide Records if Available)

	Date
Flu	/ /
Pneumonia	/ /
Hepatits B	/ /
Tetanus	/ /
HPV	/ /

Social History:

Do you Smoke?	☐ Yes	☐ No	☐ Never	----------	If yes, how much per day?
Chew Tobacco?	☐ Yes	☐ No	☐ Never	----------	If stopped tobacco use. Quit Date?
Drink Alcohol?	☐ Yes	☐ No	☐ Never	----------	Drinks per: /day /week
Caffeinated Drinks?	☐ Yes	☐ No	☐ Never	----------	Cups/Cans per: /day /week
Do you Exercise?	☐ Yes	☐ No	☐ Never	----------	Type: _____ Days per Week: _____

Family History:

Disease/Health Condition	Family Member(s)
Alzheimer's/Dementia	
Cancer	
COPD/Asthma (Chronic Lung Disease)	
Diabetes	
Heart Disease	
High Cholesterol	
Hypertension (High Blood Pressure)	
Mental Health Issues	
Stroke	
Thyroid Problems	
Other	