REAP- Community Medical Associates

System #_____ Primary Physician: _____

PATIENT REGISTRATION INFORMATION

Please fill in all questions and print clearly:

Patient's Social Security Number:_____ Date of Birth:_____ Today's Date_____

Patient's Name:_____ Home Phone:_____ Work Phone:_____

Address: _____ City:_____ State:_____ Zip code:_____

If Minor-Parent/Guardian:_____ Contact Phone: ( ) _____

Relation to Patient:_____

Other Address (Mailing) if Different Than Above:

Address: _____ City:_____ State:_____ Zip code:_____

Sex: FEMALE ( ) MALE ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( )

Referred By: _____

Patient's Employer: _____

Employer's Address: _____ City:_____ State:_____ Zip code:_____

Employer's Phone Number: ( ) _____ Ext:_____

Spouse's Name: _____

Spouse's Employer:_____

Employer's Address: _____ City:_____ State:_____ Zip code:_____

Employer's Phone Number: ( ) _____ Ext:_____

Person to Contact in Case of Emergency: _____

Phone: ( ) _____ Relation:_____

Address: _____ City:_____ State:_____ Zip code:_____

COMMUNITY MEDICAL ASSOCIATES

NO SHOW Policy

At CMA, we understand that your time- and our provider's time- is valuable. We ask that if you are unable to keep a scheduled appointment, please call and let us know at least 24 hours in advance. We will gladly reschedule your appointment.

A last minute change may result in the loss of valuable time that another patient might have utilized.

Having three (3) no shows to appointments, excessive rescheduling of appointments, or being non-compliant could lead to dismissal from our clinic.

Thank you for choosing Community Medical Associates.

_____ _____

Patient Signature Date

_____ _____

CMA Representative Date

PHI Designated Contact List

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI (protected health information) to family members, friends and/or other persons identified as involved in the patient's care of payment for the patient's health care. To comply with the regulations, as outlined in the CHS HIPAA Privacy Policy, documentation of the patient's wishes must be present in the medical record.

Unless you object, PHI can be verbally disclosed to those individuals listed below for medical purposes. Your signature also authorizes our staff to update this list per your discretion.

_____	_____	_____
Signature of Patient	Relationship, if not patient	Date

Please list ALL individuals that you authorize for verbal disclosure of medical information:

Spouse_____	Phone:_____
Significant Other _____	Phone:_____
Child_____	Phone:_____
Child_____	Phone:_____
Mother_____	Phone:_____
Father_____	Phone:_____
Sibling_____	Phone:_____
Sibling_____	Phone:_____
Grandparent_____	Phone:_____
In-Law_____	Phone:_____
Other_____	Phone:_____
Other_____	Phone:_____

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

5. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:**
I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the healthcare provider and patient are not in the same physical location.
The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

6. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).
- ☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
- ☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

7. RESEARCH STUDIES:

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____ .

8. CONSENT TO PHOTO/VIDEO:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

9. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

10. E-MAIL:

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

11. CELL PHONES:

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

12. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

Patient Label

All portions of this form *must* be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name				Date of Birth	Medical Record Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information			
Address	City	State Zip	Telephone Number
Agency or Individual(s) Authorized to Receive my Health Information			
Address	City	State Zip	Telephone Number

Health Information that may be used / disclosed is limited to the following:

☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Progress Notes ☐ Emergency Room Record
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Lab ☐ Pathology Report
☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other *(specify)* _____

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically <u>*expire 60 days*</u> after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	Expiration Date or Event	

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Patient Label

Community Medical Associates

~Adult Health Questionnaire ~

Name: _____

Date: _____ Date of Birth: _____

Preferred Pharmacy: _____ Street: _____

Past Medical History: (Please indicate YEAR of Surgery)

__None	__Breast Surgery	__ Ear tube	__Hysterectomy
__Ablation	__Cataract	__EGD	__Prostatectomy
__ Appendectomy	__Colonoscopy	__Gallbladder Surgery	__Sinus Surgery
__Back Surgery	__ C-Section	__ Heart Bypass	__Spine Surgery
__Bowel/Colon Surgery	__Device/Implant Surgery	__Hernia Repair	__Tonsillectomy

__Other (Explain below)

_____

Current Medications with Strength and Dose ___ See attached list

_____

_____

Immunization Dates

(Please write the YEAR of the Immunization, if unknown write UNKNOWN)

Flu Vaccine_____

Pneumonia _____

Tetanus_____

Hepatitis A _____

Hepatitis B _____

Measles/ Mumps _____

Chicken Pox _____

Other _____

Drug Allergies

(List Reaction to the Right)

__None __Penicillin____

__Codeine_____

__Sulfa _____

Other_____

Social History:

Smoking Status:

__Never Smoked

__Former Smoker

__Current every day smoker

__ Current some day smoker

How many packs per day?____

Smoked since age of ___

Passive smoke exposure: __Yes __No

Do you chew tobacco: __Yes __No

How many cans per day? ____

Alcohol intake:

__None

__Occasional

__Moderate

__Heavy

Illicit drug use: __Yes __No

If yes, what _____

Occupation:

_____

__ Retired

__Disabled

__ Unemployed

Marital Status:

__Single

__Married

__Divorced

__Separated

__ Widowed

__ Domestic Partner

Exercise Level:

__None

__Occasional

__Moderate

__Heavy

Caffeine Consumption?

How much? _____

Adult Health Questionnaire Community Medical Associates

Past Medical History: (check all symptoms/diseases that apply to your Past Health)

__ADD	__Cancer: Type_____	__GOUT	__Migraines
__ADHD	_____	__Headaches	__Osteoporosis
__Alzheimer's	__ Colon polyps	__Hearing Loss	__Ovarian Cyst
__Anemia/Blood Disorder	__ Congestive Heart Failure	__Heart Disease	__Palpitations
__Aneurysm	__ COPD	__Heart Murmur	__Pneumonia
__Anxiety disorder	__Coronary Artery Disease	__ Heartburn/Reflux	__Psychological disorder
__Arthritis	__Dementia	__Hepatitis/ Liver disease	__Renal Failure
__Asthma	__Depression	__High blood pressure	__Seizures
__Atrial Fibrillation	__Diabetes	__High Cholesterol	__Sleep disorder
__Back/Neck Problems	__Diverticulitis	__HIV/AIDS	__Stress incontinence
__Bipolar	__Dizziness	__Hormone issues	__Stroke
__Bladder or kidney problems	__Ear Problems	__Indigestion	__Thyroid disease
	__Edema	__Irregular periods	__Ulcer
__Blood Clots	__Endometriosis	__Kidney disease	__Urinary/Bladder problems
__Bowel problems	__Epilepsy	__Lightheadedness	__Vaginal Discharge
__Broken bones	__Eye Problems	__Lupus	__Vaginal Dryness
__Claustrophobic	_Fibrocystic Disease	__Metal Implants	__Other _____
	__GERD	__Heart Attacks	_____

Family History (Include relationship and also maternal or paternal)

__Adopted

Alcoholism_____
Allergies_____
Alzheimer's disease _____
Anemia_____
Aneurysm_____
Anxiety_____
Arthritis_____
Asthma_____
Blindness_____
Blood coagulation disorder_____
_____
Cancer & Type: _____
_____
Cataracts_____
Coronary Artery Disease_____
COPD_____
Crohn's disease_____
Dementia_____
Depression_____

Diabetes_____
Digestive disease_____
Drug dependence_____
Epilepsy_____
Glaucoma_____
Headaches_____
Hearing loss_____
Heart Disease_____
Hepatitis_____
High blood pressure_____
High cholesterol_____
Immune problems_____
Jaundice_____
Kidney disease_____
Liver disease_____
Mental disorder_____
Mental retardation_____
Multiple sclerosis_____
Osteoporosis_____
Palpitations_____
Pancreatitis_____
Parkinson disease_____
Peptic ulcer disease_____

Polyps_____
Seizure_____
Stroke_____
Thyroid disease_____
Tremors_____
Tuberculosis_____

Childhood Illness (Mark any past illnesses)

__Measles __Mumps
__Rubella __Chickenpox
__Rheumatic Fever __Polio

Hospitalizations within the past year

Reason Hospital

_____
_____
_____
_____
_____
_____
_____
_____
_____

Adult Health Questionnaire Community Medical Associates

Please name any specialist you have seen within the past 5 years.

OB/GYN_____
Allergist_____
Cardiologist_____
Ophthalmologist_____
Surgeon_____
Dermatologist_____
Urologist_____
Gastroenterologist_____
Orthopedic_____
Neurologist_____
Other_____

Prevention: (give YEAR if you have had any of the following done)

Chest X-ray_____
EKG_____
Hearing Test_____
Eye Vision Test_____
Bone Density Test_____
Colon Cancer Screening_____
Lab/Blood Tests_____

Special Learning or Communication needs? ___Spanish Speaking only __Hearing Impaired __Visually Impaired

_____

_____

_____

Men only

How many times do you urinate during the night? ____
Do you feel pain/burning with urination? ____
Any blood in your urine? ___
Has the force of your urination decreased? ___
Have you had any kidney, bladder or prostate infections within the past 12 months? ___
Do you have problems emptying your bladder completely? ___
Any difficulty with erection or ejaculation? ___
Any testicle swelling? ___
Date of last prostate exam? __/__/__
Date of last rectal exam? __/__/__
What method of birth control do you use? _____

_____

Women only

Date of last mammo __/__/___
Abnormal mammo? ____ If yes, when? _____
Date of last menstrual period __/__/____
Age at onset of menstrual period __/__/____
Date of last pap __/__/____
Abnormal pap smear? If yes, when? _____

Current method of birth control
__IUD __Depp Provera __Nuvaring
__Implanon __Diaphragm __Condoms
__Birth Control Pills __Tubal Ligation
__Spermicide __Partner Vasectomy
__Hysterectomy _None __Multiple

Number of live births ____
Number of pregnancies ____
Type of delivery?
__Vaginal __C-section __Both
Have you ever had an induced abortion? __Yes __No
If yes, when? _____