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Phone: 301-869-9776

NEW PATIENT REGISTRATION FORM

ACCT#: _____

Date: _____/_____/_____

Email Address:

Preferred Provider:

Patient Information

Last Name:	First Name:	MI:
Date of Birth:	Age:	SSN:
Address:		
City:	State:	Zip Code:
Please check primary phone Home Phone ☐	Cell Phone ☐	Work Phone ☐
Martial Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Life Partner		Gender: ☐Male ☐Female
Race:	Ethnicity:	Preferred Language:
Occupation:	Employer:	

Primary Insurance Information

☐*Check if same as patient*

Primary Insurance Name:		
Name of Policy Holder:	DOB:	SSN:
Relationship to the patient:	Employer:	
Policy #:	Group #:	

Secondary Insurance Information (Only if Applicable)

Secondary Insurance Name:		
Name of Policy Holder:	DOB:	SSN:
Relationship to the patient:	Employer:	
Policy #:	Group #:	

COMPREHENSIVE PRIMARY CARE
HEALTHCARE WITH COMPASSION

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IN CASE OF EMERGENCY

Name of friend or relative:	
Relationship to patient:	
Home Phone #:	Cell Phone #:

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Comprehensive Primary Care & Associates, L.L.C. or insurance company to release any information required to process my claims.

_____ _____

Patient/Parent/Guardian Signature *Today's Date*

* Please note: Although you have selected a Preferred Provider at CPC, there may be circumstances in which he/she is not available for appointment as desired. However, CPC has multiple providers who are willing to provide you care if this provider is not available.

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I, _____ authorize the release of my private health
Patient's Name
information to _____ _____
Name *Relationship*

I understand this information may include test results, referral information, scheduling, cancelation, or confirming appointments, as well as any other medical information pertinent to my care.

I acknowledge that this authorization is valid throughout my relationship with **Comprehensive Primary Care & Associates, L.L.C.** I understand that I may revoke this agreement at any time by submitting a request in writing.

OR

I, _____ do not want my private health
Patient's Name
information released to anyone at this time. Should I choose to designate someone at a later date, I will submit that request in writing.

SIGN BELOW

_____ _____
Patient's Signature *Today's Date*

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BILLING

Patients must pay co-pay before each visit. Any retuned check will be subject to a $30.00 charge. Pending balances will be billed to you with an additional $2.50 billing fee after your first notice. After three bills, the account will go to collections. We are happy to make payment arrangements with you.

Our office submits all claims to the insurance carrier you provide to us. We will continue to submit claims for all services we provide. Please understand that there are services your insurance carrier may consider "non-covered". For instance, smoking and/or alcohol cessation counseling, telephone evaluation and management services for those patients who have not been seen in our office in the week preceding the telephone call and are not scheduled for an appointment within 24 hours following the call. Our patients will be responsible for payment of these charges should your insurance carrier deny coverage.

Your insurance carrier defines an annual physical as "A routine evaluation and management service in the absence of patient complaints including history, physical examination, risk factor reduction intervention and the ordering of laboratory/diagnostic procedures". If an illness or injury is discovered during an annual physical examination, an additional office visit code is to be billed. Your insurance company established this billing system following their reduction (by more than 50%) in payment for annual examinations. Therefore, you may find that we have billed your insurance carrier for a preventive visit as well as an additional visit on the same date of service.

INITIAL _____

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. **There will be a $50.00 charge for missed appointments and appointments not cancelled within 24 hours.** If a message for appointment cancellation is left on the *reception desk* voicemail *only*, 24 hours prior to your appointment you will not incur a fee. We make every attempt to give our patient a courtesy call reminding you of you appointment time, but it is your responsibility to make sure you have this information so you do not miss your appointment.

INITIAL _____

REFERRALS

Your insurance company, not this office, establishes referral policies. **Please note that referrals require up to 72 hours to process.** When requesting a referral, please include your name, date of birth, insurance company name, insurance ID number, specialist name, specialty, and reason for visit. We will notify you when your referral is ready for pick up or we can send it to you via USPS Mail. We will automatically send it via facsimile or electronically to your specialist. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS**, per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please ask the front desk or you may call your insurance company.

INITIAL _____

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LAB SERVICES FOR AETNA

Our preferred laboratory is LabCorp, we are able to draw and collect specimens for this insurance, but you maybe subject to a copayment and/or a deductible. Please note , that you are fully responsible for any and all charges.

INITIAL _____

PRESCRIPTION REFILLS

In order to provide quality healthcare, please obtain an adequate supply of medication to last you until your next appointment. Your provider will give you enough refills to last until the next office visit. For example, blood pressure and cholesterol medication necessitate an office visit every 6 months. If you running out of medication please inform our medical assistant so that we may arrange for a one-time 30 day supply. In addition, we do not refill controlled substances without seeing the patient ever. For instance, Percocet, Vicodin, Tylenol #3, or the generics of any of those medications will not be refilled over the phone so please do not ask. Antibiotics are frequently over prescribed, we will only prescribe an antibiotic if we see you for your illness, and then only at the providers discretion. Coming in is not a guarantee you will receive antibiotics.

INITIAL _____

LAB RESULTS

Effective January 4, 2010, we will no longer mail results of any kind. We have implemented a new feature to improve result access for patients. This will allow patients to access a portion of their medical record securely online.

If your results are of concern due to abnormal, we will make every effort to promptly contact you. Please be sure this office has your correct telephone numbers. If you are contacted regarding abnormal results, you may be asked to schedule a follow up appointment with your provider. We understand that some patients may not have access to the web or may still want an actual copy. If you wish to obtain an actual copy of your report, you may do so by making prior arrangements with the medical assistant to pick up a copy, which we will leave at the front desk. You may also send in a self-addressed stamped envelope and we will be happy to mail you a copy.

We apologize for any inconvenience and thank you for your understanding during this transition. If you do not hear from us within 10 days after completing the test, it is your responsibility to call and obtain these results.

INITIAL _____

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PRIOR AUTHORIZATION

Your insurance company, not this office, sets medication formularies. We make every effort to adhere to these formularies, which frequently change. Effective January 1, 2006 if the medication prescribed to you is not covered by your insurance, we will be happy to change the medication to an alternative on your formulary-preferred list.

INITIAL _____

PATIENT FORMS

There will be a $25.00 fee for all forms that are dropped off during unscheduled appointments. In order to be exempt from this charge you will need to schedule an appointment with a provider. If your forms are not available at the time of service you have 7 days to drop them off to avoid the fee. After 7 days the $25.00 form fee will apply.

INITIAL _____

MEDICAL RECORDS

To obtain medical records from our office please send in a signed request with the following information:
Your full name, address, billing information, social security number, date of birth, and part of records you are requesting. For example, the entire chart or just lab results. You can mail or fax your request to this office. Under no circumstances will your original chart be given to you.

INITIAL _____

ADVANCE DIRECTIVES

Advance Directives are available at the front desk. If you would like one to fill out please ask the receptionist. Once completed please return it to any of the staff here in the office so that it can be scanned into your chart.

Communication

I, _____ consent for CPC staff and providers to use NON-HIPAA compliant bi-directional communication through my personal email and/or text.

Email:_____

Cell phone#:_____

INITIAL_____

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Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Comprehensive Primary Care and it's providers to view my external prescription history via eClinical Works EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at Comprehensive Primary Care. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCIPRTION HISTORY

Patient Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Comprehensive Primary Care & Associates, L.L.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Primary Care & Associates, L.L.C.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Done!

(FOR USE OF CPC ONLY)

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____

_____