TrueCare
MEDICAL CLINIC

613 Gault Avenue S
Fort Payne, AL 35967
(256)364-8875

PATIENT REGISTRATION FORM

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DOB: _____ **SSN:** _____

EMAIL: _____

HOME PHONE: _____ **CELL:** _____ **WORK:** _____

GENDER: _____ **MARITAL STATUS:** _____ **RACE:** _____

EMPLOYMENT STATUS: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DOB: _____ **SSN:** _____

PHONE: _____ **RELATIONSHIP TO PATIENT:** _____

EMERGENCY CONTACT: _____

PHONE #: _____ **RELATIONSHIP:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDERS NAME: _____

POLICY HOLDERS DOB: _____ SSN: _____

SECONDARY INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDERS NAME: _____

POLICY HOLDERS DOB: _____ SSN: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but it is usually not designed to pay the entire cost. Because insurance companies vary in the amount they will pay for each service, it is your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer). It is also your responsibility to ask your insurance company if they are in-network with our physician, so you will not have to pay the higher fees that occur with out-of-network coverage. Copays are due before being seen by the physician.

By signing this you are giving your consent to be treated by our physician. Also, you fully understand that you are responsible for paying what your insurance does not cover and will pay this in a timely manner.

_____ _____

PATIENT SIGNATURE ***DATE***

MEDICAL HISTORY

ALLERGIES: _____

_____

_____

MEDICATION LIST: _____

_____

_____

_____

FAMILY HISTORY: _____

_____

_____

_____

SURGERIES: _____

_____

_____

_____

SOCIAL HISTORY: _____

_____

_____

PREFERRED PHARMACY: _____

RELEASE OF INFORMATION/HIPAA

TrueCare Medical Clinic, LLC, practitioners, and employees have my permission to discuss my account or medical conditions which may include but are not limited to symptoms, treatments, diagnosis, test results, medication, and any other protected health information with the following person(s) to facilitate and coordinate my care, treatment, and payment.

The Release of Information Section applies to anyone 14 years old and older.

Please list the name, relationship, and phone # to whom protected health information may be disclosed.

NAME: _____

RELATIONSHIP: _____ **PHONE #:** _____

NAME: _____

RELATIONSHIP: _____ **PHONE #:** _____

NAME: _____

RELATIONSHIP: _____ **PHONE #:** _____

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____

PATIENT NOTICE

Patients, please read the following:

1. There will be a $25.00 charge for a broken appointment unless 24hr notice is given.
2. Payment is expected at the time services are rendered unless prior financial arrangements have been made.
3. Please notify the front desk of any changes in **address, phone, or insurance coverage** prior to your appointment.
4. It is your responsibility as a patient to make sure we have a valid referral for your visit, or you will be asked to pay for the visit in full.
5. There is a fee for copies of medical records of $1.00 per page for the first 25 pages and $0.50 for each page thereafter. This is to be paid before you receive the medical records. The fee is waived for copies of records sent directly to another attending physician.
6. There will be a fee of $25.00 for FMLA form, disability forms, and attending physician/practitioner statements needing to be completed.
7. I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a $35.00 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card from thereon.
8. I have read and/or been supplied with a copy (copy at patient's request) of the HIPAA policies of TrueCare Medical Clinic, LLC.
9. I give permission to have a photograph taken and saved in chart for identification purposes to prevent fraud. This would also help distinguish between patients having identical names.

I have read and understand this Patient Notice.

_____ _____

PATIENT SIGNATURE **DATE**