BERKELEY FAMILY PRACTICE, LLC

Jeffrey Santi, MD • Jeremy Ackermann, DO • Sarah Heincelman, MD • Samuel Adams II, DO • J. Dan Flaugher, MD • Margaret Sorrell, DO • Eric Lloyd, PA-C • Ashlyn Burns, PA-C • Britton Tucker, PA-C • Jana Chinners, PA-C • Jacob Sooter, PA-C

Registration Form

PATIENT INFORMATION

First Name	**Last Name**	**MI**
Prefix Mr. Mrs. Ms. Dr. Rev	**Sex** Male Female Other	**Marital Status** Single Married Divorced Widow/Widowerer Other
Date of Birth	**Social Security Number**	
Home Street Address	**City** **State**	**Zip Code**
Mailing Street Address ☐ SAME AS ABOVE	**City** **State**	**Zip Code**
Home Phone Number (______) ______ -____________	**Cell Phone Number** (______) ______ -____________	**Work Phone Number** (______) ______ -____________
Email	**Patient's Employer**	**Work Status:** Full Time Part Time
Race/Ethnic Group African American Caucasian Hispanic Other: ______________	**Preferred Language** English Spanish Other: __________________	

GUARANTOR INFORMATION *Person responsible for paying the bill.* ☐ SAME AS ABOVE

First Name	**Last Name**	**MI**
Guarantor Date of Birth	**Guarantor Social Security Number**	
Guarantor Street Address	**City** **State**	**Zip Code**
Home Phone Number (______) ______ -____________	**Cell Phone Number** (______) ______ -____________	**Guarantor Employer**

INSURANCE INFORMATION *Please provide us with your insurance card to make a copy.* ☐ SELF PAY

<u>Primary Coverage:</u>	
Insured Name	
Relation to Insured	
Insured DOB	
Insurance Co. Name	
ID #	
Group #	
Insurance Phone #	

<u>Secondary Coverage:</u>	
Insured Name	
Relation to Insured	
Insured DOB	
Insurance Co. Name	
ID #	
Group #	
Insurance Phone #	

EMERGENCY CONTACT

Contact Name	
Relationship to Contact	
Cell Number (_____) ______ -_________	**Alternate Number** (_____) ______ -_________

PHARMACY INFORMATION

Pharmacy Name	
Street Address, City, State, Zip Code	
Phone Number (_____) ______ -_________	**Fax Number** (_____) ______ -_________

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Records Obtain Form
(Authorization to OBTAIN Protected Health Information)

!!! ***PLEASE MAIL OR FAX RECORDS. Accepted Forms: Paper, Thumbdrives. WE DO NOT ACCEPT CDs*** **!!!**

PATIENT INFORMATION

First Name	**Last Name**		**MI**
Date of Birth	**Social Security Number**		
Street Address	**City**	**State**	**Zip Code**
Home Phone Number (______) ______ -____________	**Cell Phone Number** (______) ______ -____________	**Work Phone Number** (______) ______ -____________	

I authorize Berkeley Family Practice, LLC to OBTAIN my medical records FROM:

Name of Business / Person(s) / Entity: ____

Street Address, City, State, Zip: ____

Phone Number: ______________________ **Fax Number:** ______________________

Name of Business / Person(s) / Entity: ____

Street Address, City, State, Zip: ____

Phone Number: ______________________ **Fax Number:** ______________________

Name of Business / Person(s) / Entity: ____

Street Address, City, State, Zip: ____

Phone Number: ______________________ **Fax Number:** ______________________

Information for Treatment Period: ______________________ to ______________________
(Date) **(Date)**

I authorize the release of the following Personal Health Information including but not limited to:

- Patient Identification / Diagnosis List
- EKG / Cardiovascular
- Pathology Reports & Lab Tests
- Pulmonary Function Tests
- Office Notes / Physical Dictation
- Radiology Films & Reports
- Physical Therapy Notes
- Billing Information
- Occupational Therapy

Please initial beside each item:

_____ SENSITIVE INFORMATION: I understand that my record may include information relating to acquired immune-deficiency syndrome (AIDS) or Human Immuno-Deficiency Infection, Psychological Assessment, Behavioral and/or Mental Health Services, Sexually Transmitted Diseases, Alcohol and/or Drug Abuse and this information will be released.

_____ RE-DISCLOSURE: I understand that any disclosure of information carries with the potential for re-disclosure and the information then may not be protected by federal confidentiality rules.

_____ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

_____ EXPIRATION: : I understand that this authorization will expire 12 months after signed unless an earlier date is advised here.

_____ CHARGES: I understand that there may be a charge for releasing the requested information. RecordQuest has been contacted to provide the service and will bill you directly. Questions may be directed to RecordQuest @ 888.300.7410.

I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE, LLC AND BY SIGNING BELOW, ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE SAME.

______________________________ ______________________

Signature of Patient or Legal Representative **Date**

____

Description of Legal Representative's Authority (attach necessary documents)

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Patient Consent Form

E-PRESCRIPTION PATIENT CONSENT

Our office is now offering E-prescriptions, which are computer generated prescriptions created by your provider and sent directly to your pharmacy. There are many benefits of E-prescriptions, such as your prescriptions arriving at your pharmacy before you leave the office, you don't have to make an extra trip to drop off prescription at the pharmacy, your pharmacy notifies you when you need refills, and there is no handwriting for the pharmacist to interpret as everything is done electronically. For the benefit of your healthcare, we ask to be allowed to access your prescription history. What this does is allows us to access pharmacy's database and see your prescription history and what you are currently being prescribed by us and other providers.

_____ **YES,** I give permission for BFP to access my prescription history _____ **NO,** I do NOT give permission

Print Name: ___________________________________ Signature: __________________________________ Date: _____/_____/______

RELEASE OF MEDICAL INFORMATION

I authorize Berkeley Family Practice and other physicians involved in my medical care to release protected health information in my record to each other as allowed by law. This includes: office notes, labs, operative reports, imaging reports, insurance/billing information and medication list. I also authorize my doctors and providers to communicate with each other by phone, fax, mail or any means that they feel is necessary to optimize my medical care. I understand this information may be shared for the purposes of my treatment, obtaining payment, obtaining insurance authorizations, audits, and other necessary health care operations. Any other use of disclosure of my information requires my specific written authorization and is not allowed without such written authorization. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I, ____ DOB: ______________________, give my consent for the staff of Berkeley Family Practice to be able to release **<u>any of my medical information</u>** to:

1. Name: ____ Relation: ____________________ Phone #: _____-_____-________
2. Name: ____ Relation: ____________________ Phone #: _____-_____-________
3. Name: ____ Relation: ____________________ Phone #: _____-_____-________

_____ I do not want my information released to **<u>anyone</u>**.
_____ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

MISSED OFF APPOINTMENT AND PROCEDURE POLICY

Missed office appointments and late cancellations prevent other patients' access of care. It is therefore our policy to bill for missed appointments. You should be aware that your insurance company will NOT pay for these cancellations fees and you will be responsible for the entire amount before you will be seen at your next visit. Contact our office as soon as possible regarding any cancellations. Missed appointment or cancellation without a **<u>24 hour notice</u>** can be charged up to a **<u>$25.00</u>** fee. Medicaid patients can be discharged for multiple occurrences.

TELEMEDICINE

I acknowledge that BFP offers telemedicine services. These services may be billed to your insurance. I acknowledge these are not designed or intended or appropriate to address serious, emergency, or life-threatening medical conditions. I was given directions to find the BFP Virtual Care Online Visit Terms of Service and Privacy Policy that I may access at any time (www.berkeleyfamilypractice.com/telehealth), and acknowledge it may be updated from time to time. I acknowledge that I am solely responsible for maintaining the safety and security of my login ID and password for my healow patient portal account. I acknowledge BFP uses a shared electronic health records that allows care providers to access and use my health records as needed to provide treatment (including coordinating my care), to improve the quality of care, and in accordance with the Privacy Policy.

MEDICAL FORM COMPLETION

There will be a **<u>$25.00</u>** fee for completing any medical forms or special letters for insurance companies (other than health claims for our services), disability clams, FMLA, or similar forms. You will be responsible for these charges, should they occur. Also, an appointment will be needed to have forms completed.

DEDUCTIBLES AND COPAYS

I understand that my deductible and copay are due at the time of treatment.
I am responsible for any unpaid balances and additional collection fees.

I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE, LLC AND BY SIGNING BELOW, ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE SAME.
PATIENT SIGNATURE: ____ DATE: _____/_____/________