Patient Registration Form

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or PO Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (Check One) ❑ Male ❑ Female	Date of Birth _____ / _____ / __________	Age	Social Security #	Driver's License #
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partner	Spouse/Partner Name (if applicable)		
Employer Name	Employer Address		
Preferred Pharmacy Info Name: ______________________ Address______________________ Phone: ______________________	How did you hear about us?: ❑ Family/Friend ❑ Insurance ❑ Internet/Website ❑ Location / Drive By ❑ Newspaper/Magazine ❑ Community Event ❑ Radio / TV		

Complete this Section only if the patient is a minor

Responsible Party

Responsible Party Last Name	First Name	Middle Name	Maiden Name
Address (Street or PO Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (Check One) ❑ Male ❑ Female	Date of Birth _____ / _____ / __________	Age	Social Security #	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	
Claims Mailing Address (Street or PO Box)		
City	State	Zip
Policy/Member ID Number	Group Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone#	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip

Secondary Insurance Company	Effective Date	
Claims Mailing Address (Street or PO Box)		
City	State	Zip
Policy/Member ID Number	Group Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone#	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip

____ ______________________

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat & Financial Responsibility

Consent to Treat

I hereby authorize employees and agents of Topcare Medical, PA / MD Medical Group (including physicians, physician assistants, and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that a physician assistant/nurse practitioner is not a doctor. I also understand that a physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the State board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. I understand that at any time I can refuse to see the physician assistant/nurse practitioner and request to see a physician.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____
Patient Name (please print)

____ ________________________________
Signature of Patient, Parent, or Legal Guardian **Date**

Complete this Section ONLY if the patient is a minor

I consent for ____________________________________ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

____ ________________________________
Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize and assign payment of medical benefits directly to Topcare Medical, PA (MD Medical Group - hereinafter "MDMG"). I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment and it is due upon request. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expense of MDMG, if any, including but not limited to, a collection fee of up to 25% of the debt should my account be assigned to a collection agency for collections. I have been instructed where to review MDMG's Patient Financial Policies and Rights and Responsibilities. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing below that I am responsible for payment of services in full before services are rendered.

____
Patient Name (please print)

____ ________________________________
Signature of Patient, Parent, or Legal Guardian **Date**

Privacy Practices Notification

Acknowledgement of Receipt of MD Medical Group (MDMG) Notice of Privacy Practices

The Health Insurance Portability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act are federal government regulations designed to ensure privacy and security of patient's protected health information (PHI) and to ensure that you are aware of your rights and how your medical information can be used in providing and arranging your medical care.

MDMG is furnishing you with its Notice of Privacy Practices, which are available in hard copy or at the company's website (www.clinicasmidoctor.com ; www.mdkidspediatrics.com ; www.mdfamily.com), which provides information about how MDMG and its providers may use and/or disclose protected health information about you for treatment, payment, healthcare operations, and as otherwise allowed by law. By signing this form you acknowledge that you have received MDMG's Notice of Privacy Practices.

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Patient Name (please print)

____ ______________________________

Signature of Patient, Parent, or Legal Guardian **Date**

Communication Preferences

Communication of PHI

I hereby authorize **MDMG** to leave detailed, personal health information by the following means: (Please complete all that apply)

□ Voicemail message at my
□ home □ work □ cell number: ______________________________
(area code and number)

□ Verbal message with my spouse or partner:

______________________________ ______________________________
(name of spouse or partner) (area code and number)

□ Verbal message with other family member:

______________________________ ______________________________
(name of spouse or partner) (area code and number)

□ Send automated text messages for appointment reminders/schedule changes/notifications of normal labs or other diagnostics

I acknowledge and understand that this Authorization will be kept in my medical record and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify **MDMG** in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

____

Patient Name (please print)

____ ______________________________

Signature of Patient, Parent, or Legal Guardian **Date**

Race, Ethnicity, and Language

Race, Ethnicity, and Language

We would like you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Which category best describes your race?

- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ White
- ❑ Asian (includes Pakistan or Indian origins)
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Multiracial
- ❑ Decline

Do you consider yourself Hispanic/Latino?

❑ Yes ❑ No ❑ Decline

What language do you feel most comfortable speaking with your healthcare provider?

- ❑ English
- ❑ Spanish
- ❑ Vietnamese
- ❑ Chinese
- ❑ Tagalog
- ❑ Hindi
- ❑ Italian
- ❑ Korean
- ❑ French
- ❑ Sign Language or other Auxiliary Aid or Service
- ❑ Other ____
- ❑ Decline

Emergency Communication and Patient Portal

Emergency Communication and Patient Portal

Please choose the person that you would like to list as **Emergency Contact** in the event an emergency situation was to take place while in our office(s):

Name: ____

Contact Phone: ____

Patient Portal

- ❑ **Yes I want to communicate my information with me through a secure system that is designed to keep my information safe. You will be notified via email when there is secure information for review.**

  Email: ____

  *****Requires a signed Patient Portal User Services Agreement***

- ❑ **No I do not want to use electronic communication as a way to communicate my information to me.**

____

Patient Name (please print)

____ ____

Signature of Patient, Parent, or Legal Guardian **Date**

PATIENT ENGAGEMENT FORM

MD Medical Group dba Clinicas Mi Doctor, MD Kids Pediatrics and MD Family Clinic offers different ways on how we communicate with our patients. We have the capability to mail, email, text (SMS, MMS) and place telephone calls (including pre-recorded messages). It is each patient's responsibility to provide MD Medical Group with expressed written consent on how they would like to be notified regarding their personal health information including any marketing solicitations made by our Organization.

By consenting with this form, you agree to be contacted by MD Medical Group regarding any marketing solicitations including but not limited to preventive visits, new services, offers and/or promotions. I may be notified in any of the forms agreed to in the format below.

After every visit, you will receive a text asking to rate your service. We do not consider this part of the marketing communications, as we want to improve the service each patient receives. You are not obligated to answer the text. Message rates may apply.

Signing this form is not a condition of your medical treatment. You may continue to receive medical care even if you revoke your consent. Please note that your information will not be sold or shared with any affiliate.

I hereby give my consent to be contacted via the following method(s):

☐ Text Messages ☐ Email ☐ Mail ☐ Voice Recorded Messages

☐ Telephone Calls ☐ Promotional Materials

I also understand that I may revoke my consent in writing at any time.

____________________________________ ________________________________
Print Patient's Name Date of Birth

_________________________________ _____________________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian, if applicable

OPT-OUT OPTION:

I, __________________________________ / Date of Birth ________________ wish to opt out from receiving messages from the following format(s).

□ Text Messages □ Email □ Mail □ Voice Recorded Messages
□ Telephone Calls □ Promotional Materials

___________________________________ ________________________
Patient/Guardian Signature Date