Patient Registration Form

Last Name	First Name	Middle Name	Email for portal

Address (Street or PO Box)	City	State	ZIP Code

Home Phone #	Work Phone #	Cell Phone #	Sex ☐ Male ☐ Female ☐ Transexual

Date of Birth ____/ ____/ _____	Age	Social Security #	Driver's License # and State

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	Spouse / Partner Name (If applicable)
Which category best describes your **race**? ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American ☐ White ☐ Asian ☐ Hispanic/Latino ☐ Other	**Preferred language** ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Italian ☐ Vietnamese ☐ Hindi ☐ Tagalog ☐ Sign Language or Auxiliary Aid ☐ Other

Working Company	Employer Name	Employer Address

Preferred **Pharmacy** Info Name: ______________________________ Address: ______________________________ Phone: ______________________________	How did you **hear** about us? ☐ Family/Friend ☐ Insurance ☐ Internet/Website ☐ Location/Drive ☐ Newspaper/Magazine ☐ Radio ☐ TV ☐ Community Event

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

Name: ______________________________ Contact Phone: ______________________________

Complete this Section only if the patient is a **MINOR**:

Responsible Last Name	First Name	Middle Name	Email for portal

Address (Street or PO Box)	City	State	ZIP Code

Home Phone #	Work Phone #	Cell Phone #	Sex ☐ Male ☐ female

Date of Birth ____/ ____/ _____	Age	Social Security #	Driver's License # and State

Insurance Information:

Primary Insurance Company	Policy Number

Secondary Insurance Company	Policy Number

Patient Portal:

MDMG has different ways to communicate with our patients, as we are interested to provide the complete care you need. We use the Health and Online Wellness Portal to establish an easy and better communication between your physician's office and you.

☐ Yes, I want you to communicate my information with me through a secure system, which is designed to keep my information safe. I will be notified via email there is secure information for review.

☐ No, I do not want to use electronic communication as a way to communicate my information to me.

X ______________________________ X ______________________________ ______________________

Patient Name (Please Print name) Signature (Patient, Parent, Legal Guardian) Email

Consent to Treat

I hereby authorize employees and agents of TopCare Medical Group, Inc / MD Medical Group (including physicians, physician assistants, and nurse practitioners, as 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.

Financial Responsibility

I hereby authorize and assign payment of medical benefits directly to TopCare Medical Group, Inc (MD Medical Group – hereinafter "MDMG"). I authorize medical information needed to determine these benefits or the benefits payable for the related services, to be released to the insurance company and its agent. I understand the 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, I am responsible for payment of services in full before services are rendered.

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). They 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.mdmedicalgroup.us). They provide 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 for, you acknowledge that you have received MDMG's Notice of Privacy practices.

Rx History Consent Form

Medication History Transactions provides the health care provider with information about your current and past prescriptions. This allows to the personal to be better informed about potential medication issues and use the information to improve safety and quality. Medication history data can indicate: Compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interaction, adverse drug reactions and duplicate therapy.
The medication history information would include medications prescribed by your health care provider at TopCare Medical Group, Inc (MDMG) as well as other health care providers involved in your care and third-party pharmacy for treatment purposes. It may include sensitive information, including, but not limited to, medications related to mental health conditions, venereal diseases/ sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensible health information***.

X ____
Patient Name (Please Print)

X ____ ____
Signature of Patient, Parent or Legal Guardian Date

MD Medical Group

Consent to Treat a Minor

Please only complete this section if the patient is a Minor

I, ____, as a legal guardian of ____ who was born on ____ / ____ / _____, authorize the evaluation and treatment for the patient identified above whenever I am not available. I understand that this authorizes the foregoing person(s) to consent for medical and surgical procedures and immunizations related with the healthcare needs of the patient. The duration of this consent is indefinite and continues until revoked in writing.

(Spanish)
Yo, ____, como tutor legal de _____________________________________ quien nació el ____ / ____ / _____, autorizo su evaluación y tratamiento la fecha en la que yo no me encuentre disponible. Entiendo que esto autoriza a las siguientes personas de aprobar procedimientos médicos, quirúrgicos o vacunas, importantes para la salud del paciente. La duración de este consentimiento es indefinida y continúa hasta que se revoque por escrito.

Complete Name / Nombre Completo	Relationship / Relación	Phone Number / Teléfono
1.		
2.		
3.		

X ____ ____
Signature of Parent or Legal Guardian / *Firma del Tutor* Date / *Fecha*

MD Medical Group

Communication of Protected Health Information

MDMG (Clínicas Mi Doctor, MD Kids Pediatrics, MD Family Clinic) offers different ways on how we communicate with our patients. We have the capacity to mail, email, text (SMS, MMS) and place telephone calls. It is each patient's responsibility to express with expressed written how they would like to be notified regarding their personal health information. All will remain in effect until they are revoked by the patient in writing or a change of one or more of the listed telephone numbers.

I hereby authorize MDMG to ***leave detailed health information*** by the following means: (Mark all that apply).

☐ Voicemail message at my:
☐ Home ☐ Work ☐ Cell Number

____
(Area code and Number)

☐ Verbal Message with other person
Name:

____
(Area code and Number)

Name of Person you wish to receive PHI ___________________________ **Relationship** _________________________

By consenting with this form, you agree to be contacted by the MD Medical Group regarding any marketing solicitations.

I hereby give my consent to be contacted via the following method(s) for ***marketing solicitations***, as preventive visits, new services, offers and/or promotions. I may be notified in any of the forms agreed in the format below.

☐ Text Messages ☐ Email ☐ Mail
☐ Voice Recorded messages ☐ Telephone Calls ☐ Promotional Materials.

X _____________________________ ___ / ___ / ___ X ____ ________
Patient's Name (Please Print) Date of Birth Signature of Patient, Parent or Legal Guardian Date

OPT OUT OPTION

☐ I, __________________________________ with DOB ____ / ____ / _____, wish to **OPT OUT** from receiving messages and understand that I may continue to receive medical care even if I revoke my consent.

____ ____ / ____ / _____
Patient's Name (Please Print) Date of Birth

____ ____ / ____ / _____
Signature of Patient, Parent or Legal Guardian Date

Authorization for Use or Disclosure of Medical Record Information

Patient Full Name:			Date of Birth: ____ / ____ / ______
Patient Address:			Home Phone:
City:	State:	Zip Code:	Work Phone:

Receipt of Medical Record Information

I hereby authorize: ____
____
____ to release my medical record information to:

TopCare Medical Group, Inc **Attention:** ______________________________________

Address:____ **Phone:** ________________________

City: ________________________ **State:** __________________ **ZIP Code:**__________ **Fax:** ___________________________

Purpose of Request: O Personal O Continuing Care O Transfer Out (Specify Reason)

Information to be Released

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization. I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon one (1) year.

I also understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment.

____ ____ / ____ / _____
Signature of Patient, Parent or Legal Guardian Date

Authorization to Release Protected Information

Please put a checkmark in ALL the check boxes below, indicating how protected information should be handled even if the categories are applicable or not to the patient's medical records. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Initials

I DO ☐ ☐ **DO NOT** want all Medical Records released ________
I DO ☐ ☐ **DO NOT** want Psychiatric Treatment Notes released ________
I DO ☐ ☐ **DO NOT** want information about Mental Health released ________
I DO ☐ ☐ **DO NOT** want information about HIV Tests & related information released ________
I DO ☐ ☐ **DO NOT** want information about Alcohol and/or Substance Abuse released ________
I DO ☐ ☐ **DO NOT** want information about (other sensitive information) ____________ released ________

_________________________________ ____ / ____ / _____
Patient's Signature Date

_________________________________ ____ / ____ / _____
Parent / Legally Recognized Representative Signature Date

_________________________________ ____ / ____ / _____
Witness Date