PERRY MEDICAL CLINIC
401 Northwood Drive, Centre, AL 35960

PATIENT REGISTRATION FORM
Date: _____

PATIENT INFORMATION

Patient's Last Name: First: Middle: (preferred/Nickname)		Marital Status (Circle One) Single / Mar / Div / Sep / Widow		
Spouse/Parent Name:	Social Security Number:	Birth Date: / /	Age:	Gender: ❑ M ❑ F
Home Address:	City/State/Zip	Home Phone: ( ) Cell Phone: ( )		
Employer Name and Address:	City/State/ZIP	Work Phone ( )		
Email:	Preferred Pharmacy	Pharmacy Phone: ( )		

RESPONSIBLE PARTY

Name:	Social Security # Date Of Birth / /
Address:	Home Phone ( ) Cell Phone ( )

ILLNESS / ACCIDENT / INJURY INFORMATION

If accident/ injury, how did it happen:		Onset symptom/ accident date: Date Last Worked:
Is this a Workman's Compensation Case? ❑ Yes ❑ No	If Yes, please complete the following:	
Employer Name / Location:	WC Claim # / Approved By:	Employer Phone No.:
WC Insurance Carrier Name:	Insurance Address:	( ) Insurance Phone No.:

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name:	Policy Holder Name:	Contract No.:
Patient's Relationship To Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other	Policy Holder Birth Date: / /	Policy Holder SSN:
Group No.:	Co-Payment: $	Employer Phone No: ( )
Employer Name:		

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name:	Policy Holder Name:	Member/Policy/Contract No.:
Patient's Relationship To Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other	Policy Holder Birth Date: / /	Policy Holder SSN:
Group No.:	Co-Payment: $	Employer Phone No.: ( )
Employer Name:		

The above 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 due. I will be financially responsible for any collection balance or fees required to collect any outstanding balance. I also authorize Perry Medical Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ *Date* _____

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:
Address:	Phone Number:

I authorize Perry Medical Clinic to provide information about my treatment and care to the following person(s). Please list spouse, if applicable.

I. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

II. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

III. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

_____ **(please initial)** I authorize Perry Medical Clinic to leave a general voice message, test results, or appointment reminder on my home phone or my cell phone voice mail. Please check the box (es) below that you would like a message left at.

☐ Home Phone ☐ Cell Phone ☐ Work Phone

_____ **(please initial)** I authorize Perry Medical Clinic to fax my medical information to other healthcare providers.

This authorization will remain in effect until I revoke it in writing by notifying the Privacy Officer at the Perry Medical Clinic, 401 Northwood Drive, Centre, Alabama.

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at the Perry Medical Clinic, 401 Northwood Drive, Centre, Alabama.
- I may request a copy of this completed and signed authorization form.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Authorized Signature Date Signed

Relationship to Patient (if signed by personal representative)

PERRY MEDICAL CLINIC, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: This Notice of Privacy Practices describes how we may use and disclose your protected health information. Not every use or disclosure will be listed, however, all of the ways we are permitted to use and disclose information will fall within one of the following categories.

- **Treatment:** We may use your protected health information to provide, coordinate, or manage your health care and any related services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or at the hospital. We may also disclose medical information about you to people outside the practice who may be involved in your medical care such as family members, clergy or other persons that are part of your care.
- **Payment:** Your protected health information may be used and disclosed to obtain payment for your health care services provided by us or by another provider. For example, we may disclose your protected health information to an insurance company so that we can get paid for treating you.
- **Health care operations:** We may use or disclose your protected health information in order to support the business activities of the practice. These activities are necessary to run the practice and to ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and workers' compensation.

NOTICE OF INDIVIDUAL RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information about you for so long as we maintain the protected health information. We may deny your request in certain very limited circumstances.

RIGHT TO REQUEST RESTRICTIONS: This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. ***We are not required to agree to your request***. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. You must make your request writing to the Privacy Officer.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer and specify how or where you wish to be contacted.

RIGHT TO AMEND: If you believe that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. You must make your request to the Privacy Officer and you must provide a reasonable explanation. We may deny your request.

RIGHT TO ACCOUNTING OF DISCLOSURES: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

RIGHT TO A PAPER COPY: You have a right to receive a paper copy of this notice upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of Health and Human Services. To file a complaint with the practice, submit your complaint in writing to the **Privacy Officer.** You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE: We reserve the right to change this notice.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or laws that apply to use will be made only with your written authorization. If you give us permission to disclose medical information about you, you may revoke that permission in writing, at any time.