Family Medical & Maternity Care, P.C. ~ Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: ___ /___ /_____ Sex: M / F Email: _____

☐ Please send text message appointment reminders ☐ Please sign me up for "Patient Portal!"

Mailing Address: _____ P.O. Box / Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: (_____) _____ - _____ Cell Phone #: (_____) _____ - _____

Work Phone #: (_____) _____ - _____ PRIMARY contact # *(circle one):* Home / Cell / Work

PLEASE CIRCLE ONE IN EACH BOX:

Ethnicity:	***Language:***	***Race:***
Hispanic/Latino	English	African American/Black
Non-Hispanic/Latino	Spanish	American Indian or Alaska Native
Other / Decline to Specify	Other	Asian
		Caucasian/White
		Hawaiian/Pacific Islander
		Other Race / Decline to Specify

Primary Emergency Contact Name: _____

Phone Number: (_____) _____ - _____ Relationship: _____ Legal Guardian? Y / N

Secondary Emergency Contact Name: _____

Phone Number: (_____) _____ - _____ Relationship: _____ Legal Guardian? Y / N

Additional Emergency Contact Name: _____

Phone Number: (_____) _____ - _____ Relationship: _____ Legal Guardian? Y / N

Acknowledgement of Patient Privacy Rights (HIPAA)

I, _____ *(print name)* hereby acknowledge that I have received a copy of Family Medical and Maternity Care, P.C.'s *Joint Notice of Information Practices.* I understand that this notice describes how the practice uses and discloses my medical and billing information as well as a description of my rights and how I may obtain additional information.

_____ _____ _____

Signature of Patient/Parent/Legal Representative *Date* *Relationship to Patient*

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"No-Show" Policy: FMMC defines a "no-show" appointment as any scheduled appointment in which the patient (1) Does not arrive for appointment and does not call the office (2) Cancels an appointment less than one hour before the scheduled appointment time with an inappropriate reason (3) Arrives late to their appointment without calling ahead and is consequently unable to be seen. *After continued infringements of the FMMC, P.C. "no-show" policy, we reserve our right to discharge the patient from our practice, as we may no longer feel comfortable managing the care of this patient who chooses to continually jeopardize his or her own healthcare, or that of their children.*

_____	_____	_____
Signature of Patient/Parent/Legal Representative	*Date*	*Relationship to Patient*

Financial Policy: FMMC, P.C. requests prompt payment of all outstanding financial balances. If you have any questions regarding your bill or your insurance company's *Explanation of Benefits (EOB)* statement, please call our office. We recognize that some of our patients may experience financial difficulties at times, so please let us know if we can assist you with creating a comfortable payment plan that will accommodate your family's budget. Unfortunately, failure to comply with this policy may result in discharge from the practice.

_____	_____	_____
Signature of Patient/Parent/Legal Representative	*Date*	*Relationship to Patient*

Narcotic Policy: FMMC has a strict policy for managing controlled substances. All controlled substances are filled for 28 day supplies only. Opiate pain medications require a patient to review and sign a narcotic agreement (available for review on our website) which reviews the risk and benefits associated with opioid pain medications, consent for random urine tox screening, pill counts, and medication checks at least every 120 days. This document also details the ramification of any violation of the agreement. Please note that no controlled substance will be filled at your first visit at FMMC. Records from your previous provider are required in order for the FMMC provider to even consider assuming management of your medications.

_____	_____	_____
Signature of Patient/Parent/Legal Representative	*Date*	*Relationship to Patient*

I hereby authorize medical treatment for myself and the release of any medical information necessary to process all insurance claims to my insurance carrier(s) and the payment of such directly to Family Medical & Maternity Care, P.C. (FMMC). I also understand and acknowledge that any charges for medical care provided that are either not covered by my medical insurance or not reimbursed directly to FMMC, including all plan deductibles, are my personal financial responsibility. I hereby acknowledge that all fees, costs, etc. (including legal fees and court costs) associated with the collection of any unpaid fees are also my personal responsibility. I hereby acknowledge that the details (what "covered charges" are; what the annual and per visit deductible costs are, etc.) of the medical insurance coverage that I have is solely my responsibility to understand prior to any medical care provided to me by FMMC; as well as all tests, lab work and other related medical activity recommended to me by FMMC. I also hereby authorize the staff of FMMC to view my prescription history through external resources.

_____	_____	_____
Signature of Patient/Parent/Legal Representative	*Date*	*Relationship to Patient*