



Patient Registration / HIPAA and other consents

All shaded areas MUST be completed

Patient Name: Last: _____ First: _____ Middle: _____ Maiden: _____

Date of Birth: _____ Age: _____ Sex: Male / Female Social Security #: _____ - _____ - _____ Marital Status: _____

Physical Address: _____ City/State/ZIP: _____

Mailing Address: _____ City/State/ZIP: _____

Phone Home: (____) _____ - _____ Cell: (____) _____ - _____ Work: (____) _____ - _____ ext: _____

Employer: _____ City/State/ZIP: _____ Email: _____

Consents & Contacts: Please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. NOTE: If the patient is a minor, parent(s) must be listed

Name: _____ Relationship to Patient: _____ Phone: (____) _____ - _____

Name: _____ Relationship to Patient: _____ Phone: (____) _____ - _____

Name: _____ Relationship to Patient: _____ Phone: (____) _____ - _____

If you would like TotalCare to file with your Insurance these fields MUST be completed.

Primary: Insurance Company: _____ Policyholder: Last: _____ First: _____ MI: _____
Policy ID number: _____ Group number: _____
(Policyholder Info) Relationship to Patient: _____ Social Security #: _____ - _____ - _____ Date of Birth: _____
Address: _____ City/State/ZIP: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Secondary: Insurance Company: _____ Policyholder: Last: _____ First: _____ MI: _____
(Policyholder Info) Relationship to Patient: _____ Social Security #: _____ - _____ - _____ Date of Birth: _____
Address: _____ City/State/ZIP: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Voicemail Consent: For your convenience, TotalCare will call to remind you about your upcoming appointments. Please check the following phone lines on which we may leave detailed information on:

- home voicemail mobile phone voicemail work voicemail I do not wish TotalCare to leave details on my voicemail.

By signing below I certify the above information to be true and correct.

Notice of Privacy Practice Acknowledgement: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Insurance (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that TotalCare has the right to change its Notice of Privacy Practices from time to time and that I may contact TotalCare at anytime at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that TotalCare restrict how my PHI is used or disclosed to carry out treatment, payment and health care operations.

I am aware that for my safety and protection, video and audio surveillance may be used on TotalCare premises, in public areas only.

I, the undersigned, as patient or on behalf of patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained. I understand that I have the right to revoke this consent, in writing, except where Total Care has already made disclosures in reliance on my prior consent. A photocopy of this signature is as valid as the original.

Patient or Parent/Guardian Signature: _____ Date: _____

Print Patient or Parent/Guardian Name: _____ Parent/Guardian DOB: _____

Guardian/Power of Attorney: Please see the front desk for additional documentation (required by law) to be completed.