Registration & Privacy Consents

Patient Information

Last Name: _____ First Name: _____ MI: ____ Maiden: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Sex: Male / Female Driver's License #: _____ State Issued: _____

Marital Status: _____ Primary Phone: (_____) _____-_____ Email: _____

Physical Address: _____ City/State/ZIP: _____

Mailing Address: _____ City/State/ZIP: _____

Employer: _____ Work Phone: (_____) _____-_____ Ext: _____

Parent or Legal Guardian Information (if patient is a minor)

Last: _____ First: _____ MI: _____

Relationship to Patient: _____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Driver's License #: _____ State Issued: _____

Address: _____ City/State/ZIP: _____

Primary Phone: (_____) _____-_____ Work: (_____) _____-_____ Ext: _____

Insurance Information

☐ **Check here if patient is uninsured.**

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

Primary Insurance:

Insurance Company Name: _____

Policy ID number: _____ Group number: _____

Policyholder Information *(if different from patient)*: Last: _____ First: _____ MI: _____

Relationship to Patient: _____ Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Policyholder Address: _____ City/State/ZIP: _____

Primary Phone: (_____) _____-_____ Work: (_____) _____-_____ Ext: _____

Secondary Insurance:

Insurance Company Name: _____

Policy ID number: _____ Group number: _____

Policyholder Information *(if different from patient)*: Last: _____ First: _____ MI: _____

Relationship to Patient: _____ Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Policyholder Address: _____ City/State/ZIP: _____

Primary Phone: (_____) _____-_____ Work: (_____) _____-_____ Ext: _____

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: (_____) _____-_____

Voicemail and Text Message Consent

Please initial if you would like to allow TotalCare to send text messages and/or leave detailed voicemails on your primary number.

_____ Text Message _____ Detailed Voicemail

Online Patient Portal Registration

Crowley Patients Only*

TotalCare Crowley offers an online tool to our patients that allows you to connect with us conveniently and privately from your own home, office or mobile app. With this service you can view your lab results*, receive electronic appointment reminders and request medication refills, update personal data, view billing information and other additional features.
**If all results are within normal range. If results are abnormal, our medical staff will still contact you by phone.*

Email Address: _____ or __ I do not wish to register for the patient portal.

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 any time at the address below 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 am aware that TotalCare will request my photo ID and insurance card at each visit, and that this information will be kept on file with my records.

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 TotalCare has already made disclosures in reliance on my prior consent. A photocopy of this signature is as valid as the original.

By signing below, I certify that all information on this form to be true and correct.

Patient **Signature:** _____ **Date:** _____
(Parent/Guardian if minor)

Patient Name **PRINT**: _____ Patient **DOB**: _____
(Parent/Guardian if minor) (Parent/Guardian if minor)

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