

Patient Registration Form

PATIENT INFORMATION

(Please Print)

Dr. Mr. Mrs. Ms. Jr. Sr. Other
Patient's Name (Last) (First) (Middle)
Also Known As Name (Last) (First)
Marital Status Married Single Divorced Widowed Legally Separated Other
Social Security Number Female Male Date of Birth
E-Mail Address
Phone Numbers Work Day Evening Home Day Evening Cellular Pager
Address
City, State, ZIP (+4)
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer Occupation
Emergency Contact Name Phone Number
Emergency Contact Relationship to Patient
Referring Provider Name

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) (First) (Middle)
Also Known As Name (Last) (First)
Social Security Number Female Male Date of Birth
E-Mail Address
Phone Numbers Work Day Evening Home Day Evening
Address
City, State, ZIP (+4)
Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed
Employer Employer Phone Number
Patient Relationship to Responsible Party

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured Patient Relationship to Insured
Insured Employer Name
Insurance Company/Phone Number
Subscriber ID (Policy Number) Group ID Copay Amount
Effective Date Termination Date Female Male
Insured Date of Birth Insured's Social Security Number
Insurance Company Address

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured Patient Relationship to Insured
Insured Employer Name
Insurance Company/Phone Number
Subscriber ID (Policy Number) Group ID Copay Amount
Effective Date Termination Date Female Male
Insured Date of Birth Insured's Social Security Number
Insurance Company Address

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date



# Reston Breast Care Specialists

We are committed to providing you with the best possible care. If you have medical insurance, we strive to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

## PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE PROVIDED

We accept cash, checks and Visa/MasterCard. We will be happy to process claims for those PPO's and HMO's with which we participate, but you will be expected to pay any copay or percentages of deductibles at the time of service. We participate with most major carriers and therefore will file the claim on your behalf. For other insurance companies, you are responsible for all fees at the time services are provided. We will provide you with information so you may file with your insurance company.

We must emphasize that as medical providers, our relationship is with you and not your insurance company. All charges are your responsibility from the date the services are rendered. If someone else is presumed liable for a bill, such as a divorced spouse or parent, we will look to the patient or if a minor, the guardian, for payment of services. We gladly provide you with a receipt for payment. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly, and prior to your office visit, for assistance in the management of your account.

Returned checks and balances older than thirty days may be subject to additional collection fees. We will gladly discuss your charges prior to your visit, as well as, any relating to your insurance. You must realize, however, that:

- 1- Your insurance is a contract between you, your employer, and the insurance company.
- 2- Not all services are a covered benefit in all contracts. You may wish to contact your insurance carrier for information regarding coverage. For example: Many insurance companies do not cover routine exams or supplies, such as crutches.

Please help us by updating your registration sheet with the receptionist when changes occur such as new employer, insurance or new home address. If you have any question about our office, please do not hesitate to ask. We are here to help you.

Initials \_\_\_\_\_

\_\_\_\_\_ agree that I am fully responsible for my bill if at any time my insurance denies payment. I am responsible for making sure my insurance is currently active and participating with the provider that I am seeing. If I am seeking urgent care treatment, I agree that I will pay the urgent care co-pay that has been established by my insurance company. I also agree that if I have a balance after my insurance has paid, that I will be responsible for the remaining balance due.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### How did you hear about our office?

Physician Referral (Name) \_\_\_\_\_  
 Emergency Room \_\_\_\_\_  
 Mailbox Flyer \_\_\_\_\_

Insurance Assignment \_\_\_\_\_  
 Personal Reference \_\_\_\_\_  
 Signs \_\_\_\_\_



Reston  
Breast Care Specialists

**PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Account or Med. Rec. # \_\_\_\_\_

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions <i>(i.e.: may pick up meds, may disclose test results, etc)</i>	Patient/ Guardian Initials

**THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)**

Leave message at home with my spouse or:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DOB: \_\_\_\_\_

Leave message on cell phone.

Cell phone number: \_\_\_\_\_

Leave message at work.

Work phone number: \_\_\_\_\_

Leave message on voicemail.

Phone number: \_\_\_\_\_

Leave a detailed message on answering machine.

Phone number: \_\_\_\_\_

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.


Patient Chosen Identifier/Password: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship (if not self)

HCA Physician Services  
 Reston  
Breast Care Specialists  
Patient Consent Form

*(Please Read and Sign)*

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I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Reston Breast Care Specialists may include consent at satellite offices under common ownership.

I, the undersigned, authorize Reston Breast Care Specialists to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Reston Breast Care Specialists.

I acknowledge that I have been given the Reston Breast Care Specialists Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

<b>Section A: This section must be completed for all Authorizations</b>					
<b>Patient's Name:</b>		<b>Birth Date:</b>		<b>Social Security Number:</b>	
<b>Provider's Name:</b>		<b>Recipient's Name:</b>			
<b>Provider's Address:</b>		<b>Address 1:</b>			
		<b>Address 2:</b>			
		<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>Expiration Date or Event:</b> This authorization will expire on the following expiration date (or) expiration event: <b>Date:</b> <b>Event:</b>					
<b>Purpose of Disclosure:</b>					
<b>Description of Information to be Used or Disclosed</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date of Service:</b>	<b>Description:</b>	<b>Date of Service:</b>	<b>Description:</b>	<b>Date of Service:</b>
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Admission Form <input type="checkbox"/> Dictation Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Intake/Output <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special Test/Therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer Forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/Delivery Summary <input type="checkbox"/> OB Nursing Assess <input type="checkbox"/> Postpartum Flow Sheet <input type="checkbox"/> Itemized Bill: <input type="checkbox"/> UB-92 Claim: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
<b>I understand that:</b>					
<ol style="list-style-type: none"> <li>1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.</li> <li>2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.</li> <li>3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.</li> <li>4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.</li> <li>5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.</li> <li>6. There may be a reasonable fee to obtain a copy of the information being requested on this form.</li> <li>7. I get a copy of this form after I sign it.</li> <li>8. Note: There will be a charge for records in accordance with the VA code 8.01-413 \$0.50 (Per page up to 50 pg) Additional \$0.25 per page (from page 51 &amp; up) + actual postage.</li> </ol>					
<b>Section B: Is the request of PHI for the purpose of marketing?</b>					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:					
<b>Section C: Required Signatures</b>					
<b>I have read the above and authorize the disclosure of the protected health information as stated.</b>					
<b>Signature of Patient/Guardian/ or Personal Representative:</b>				<b>Date Signed:</b>	
<b>Printed Name of Patient/Guardian/ or Personal Representative:</b>				<b>Relationship of Personal Representative to Patient:</b>	