Generations Primary Care Patient Registration

(Please complete all information – Please Print)

Patient Name _____

Date of Birth _____Age _____Sex_____Race _____

Social Security #_____Marital Status _____

Driver's License#_____Expiration Date_____State _____

Address _____

Phone# Home _____Cell _____Work_____

Pharmacy Name_____

Patient's Employer _____

Parent(s) Name (if patient is a minor) _____

Please present insurance card(s) to receptionist

Primary Insurance Carrier_____

Policy Number_____Group Number _____

Secondary Insurance Carrier _____

Policy Number_____Group Number _____

Required information	Primary Insurance	Secondary Insurance
Insured's Name		
Insured's Date of Birth		
Insured's Social Security Number		
Insured's Relationship To Patient		
Insured's Employer		

Emergency Contacts Not Living With You:

Name _____Phone _____ Relationship _____

Name _____Phone_____Relationship _____

Patient Medical Information

(Please Print – Please Complete All Information)

Patient Name_____Date of Birth_____

Allergies: Food____ Drug____ Other____ Please list allergen and reaction: _____

_____

Physicians (previous/current) _____

_____

Previous/Other Medical Problems _____

_____

_____

Current Medications and Dosage _____

_____

_____

_____

_____

Please List Hospitalizations and Surgeries

Reason for Hospitalization of Type of Surgery	Location	Date	Physician

Family History

Living Age/Health Problems	Deceased Age/Health Problems	Has Any Blood Relative Ever Had:	Please Circle		Who
Father		Cancer	No	Yes	
Mother		Tuberculosis	No	Yes	
Siblings 1.		Diabetes	No	Yes	
2.		Heart Trouble	No	Yes	
3.		High Blood Pressure	No	Yes	
4.		Stroke	No	Yes	
5.		Epilepsy	No	Yes	
6.		Mental Illness	No	Yes	
Spouse		Suicide	No	Yes	
Children1.		Depression	No	Yes	
2.		Thyroid Disease	No	Yes	
3.		Arthritis	No	Yes	
4.		Other			
5.					
6.					

Generations Primary Care Financial Policy

Generations Primary Care, PSC is committed to meeting your health care needs. We are pleased that you have chosen us. Our goal is to provide the very best possible care for you. We have prepared this information regarding our services and fees to help keep your insurance or other financial arrangements as simple as possible. We ask that you adhere to the following guidelines:

- It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit,
- All co-payments are due at the time of service. Deductibles and coinsurance will be billed to you.
- You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a $30.00 returned check charge.
- It is your responsibility to contact your insurance carrier to confirm that our providers participate in your insurance plan. If you see a provider that is not currently on your plan, you will be responsible for payment in full.
- Your provider may choose to assess fees to fill out detailed forms/documents such as FMLA; disability; short-term disablilty; accident reimbursement plans; employer wellness; etc. Fees are posted in each examination room.
- You will be responsible for all non-covered services that your insurance carrier denies for payment.
- It is your responsibility to provide a 24-hour appointment cancellation notice. If you miss your appointment and fail to contact our office then a "NO SHOW" fee may be applied to your account as determined by your provider. This charge is considered a non-covered service therefore your insurance carrier will not pay this fee; this charge will be billed directly to you.
- If you request treatment and refuse to be seen in office (ex: request antibiotic for sinus infection), a “FEE FOR TREATMENT REQUEST WITHOUT OFFICE VISIT” fee may be applied to your account as determined by your provider. This charge is considered a non-covered service therefore your insurance carrier will not pay this fee; this charge will be billed directly to you.

I understand regardless of any insurance coverage I may have; I am responsible for any outstanding balance due. If I am covered by an insurance plan that my provider participates with, I agree to pay my co-pay or deductible at the time of service. I authorize payment of medical benefits to the provider and allow Generations Primary Care to submit claims to my insurance carrier on my behalf. If I am covered by an insurance plan that my provider does not participate with, or if I have no health insurance coverage, I agree to payment in full at the time of service. In the event of default in payment, I agree to pay reasonable collection fees, including a reasonable attorney's fee.

By signing below, I agree to the terms listed above.

Patient Name (Please Print) _____Date of Birth_____

Patient/Guarantor Signature_____Date_____

Guarantor Name (Please Print) _____

Generations Primary Care Acknowledgement and Consent Form

Patient Name (Please Print)_____Date of Birth_____

Consent for Blood Sample and Testing

I give consent that in the event an employee of Generations Primary Care, PSC should be exposed to my blood a sample of my blood will be tested for hepatitis B, hepatitis C and HIV. I understand that the blood sample will be sent out to a laboratory for testing, and that the test results will be released directly to the exposed employee. I further understand that the test results will NOT be released to any other individual in the practice, including owners, physicians, management and other employees. The exposed employee will hold the test results confidential; consulting only with the healthcare professional that is conducting the follow-up evaluation for the incident. Generations Primary Care, PSC will absorb the cost for the testing.

Patient/Guarantor/Other Signature_____Date_____

Relationship to patient if signature by guarantor/other_____

Notice of Privacy Practices Patient Acknowledgement

I have received and understand the Notice of Privacy Practices for Generations Primary Care PSC. The notice provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice; my individual rights; how I may exercise these rights and the practice's legal duties with respect of my information.

I understand that Generations Primary Care PSC reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information (PHI) resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Patient/Guarantor/Other Signature_____Date_____

Relationship to patient if signature by guarantor/other_____

Medicare Shared Savings Program/ ACO Participation Acknowledgement
Medicare Beneficiaries Only

As a Medicare beneficiary, I understand that in order to provide better, more coordinated health care, my provider has chosen to participate in an Accountable Care Organization (ACO) through the Medicare Shared Savings Program. My provider will work together with other doctors, hospitals and healthcare providers to share resources and information to ensure that I receive the right care at the right time in the right setting. I understand that I may choose to have my name and other personal information removed from the information Medicare shares with healthcare providers and organizations by contacting Medicare directly or requesting a form from my provider. An informational sheet has been made accessible to me by my provider's office, Generations Primary Care PSC.

Patient/Guarantor/Other Signature_____Date_____

Relationship to patient if signature by guarantor/other_____

Patient Authorization for Personal Representative

Purpose of request -I authorize Generations Primary Care, PSC to disclose or provide all of my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information.

Expirations or termination of authorization - Right to revoke or terminate – This authorization will remain in effect until terminated by you, your personal representative or other individual(s) or legal entity authorized to do so by court order or law. As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure - We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Generations Primary Care, PSC.

Patient Name (Please Print) _____Date of Birth_____

Patient/Guarantor Signature_____ _____ Date_____

____ I DO NOT choose to authorize any individual to act as my personal representative.

____ I choose to authorize the following individual(s) to act as my personal representative:

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____

(Please Print)
Personal Representative Name_____

Address_____

Phone Number_____

Patient Portal/Patient-Provider E-mail
Authorization to Use or Disclose Protected Health Information via Electronic Media

Patient Name (Please Print) _____ Date of Birth_____

Email Address (Please Print)_____

By signing this form, I authorize Generations Primary Care (GPC) to communicate via personal, secured access patient portal with me for my medical care and treatment. GPC will provide notices via my personal email that information can be found in my patient portal. No personal health information is transmitted via or into my personal email. I understand that the following types of protected health information (PHI) may be used, disclosed and retained by the healthcare providers of GPC as a result of the communications:

1. My personal health information
2. Electronic displays of radiological images (x-rays)
3. Laboratory test results
4. Pathology reports
5. Other diagnostic test results

Patients and /or personal representatives who want to communicate with their healthcare provider by clinic portal should consider all of the following issues before signing this authorization:

1. Portal communication is a convenience and not appropriate for emergencies or time sensitive issues.
2. Portal messages received at GPC can be forwarded, printed and /or read, stored by GPC staff members.
3. We advise caution when communicating highly sensitive or personal information via portal messages (i.e. HIV status, mental illness, chemical dependency, and worker compensations issues)
4. Clinically relevant messages and responses will be documented in the medical record.
5. GPC will not be liable for information lost or misdirected due to technical errors or failures.
6. GPC does not own or have any interest in the portal website. E-MDS portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to Generations Primary Care. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. I understand that I may refuse to sign this authorization. I also understand that Generations Primary Care cannot deny or refuse to provide treatment, payment or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

Patient/Guarantor Signature_____Date_____

GENERATIONS
Primary Care
270 Burley Avenue ♦ Hopkinsville ♦ KY ♦ 42240
Telephone: 270-887-6767 ♦ Fax: 270-887-6161

Patient Authorization for Disclosure to Designated Provider
Authorization to Release Medical Record Information

GPC Provider: _____ Patient SS#: _____

Patient Name (please print): _____ DOB: _____

Purpose of Request - I request and authorize the disclosure or release of my protected health information (as identified below) **TO** or **FROM** (circle one) following provider:

Name of practice: _____

Name of provider: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax:_____

Description of information to be disclosed **–** I authorize the disclosure of the following protected health information about me to the person(s) identified above.

_____ Complete medical record (to include any and all information regarding HIV (aids) and testing, sexual abuse, spouse or child abuse, mental illness and substance abuse including controlled substance or alcohol abuse): or

_____ Only the following information: _____

_____

Purpose of disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

Expirations or termination of authorization **–** This authorization will expire within _____ days from the date of my signature below.

_____ _____
Patient Signature Date

_____ _____
Signature of Authorized Person Relationship to Patient

_____
For Office Use Only

Date records received _____ Employee initials _____
Date mailed _____ Employee initials _____