



## Patient Registration Form

### Patient Information (full legal name):

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  Male  Female

Community Name: \_\_\_\_\_ City/State: \_\_\_\_\_

### Insurance Information:

Medicare ID #: \_\_\_\_\_ (Please attach copy of Medicare ID card)

Primary Plan: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Plan: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Legal Representative (healthcare decision maker):

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Self: I make my own medical decisions and have no Medical Power of Attorney or Healthcare Directive

### Billing Contact:

Same as Healthcare-decision maker  Self

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Code Status:  Full Code  DNR  Other

### Checklist of Registration Information:

- Authorization for Release of Health Information (page 2 completed)
- Power of Attorney/POA Document (if applicable)
- Copies of ALL Insurance Cards
- Current History & Physical (H&P) from Provider (Face Sheet, Diagnosis, Current Medication List)

**I have read and agree to Hometown Physician Services Patient HIPPA Acknowledgement, Consent for Services and Insurances and Notice of Privacy Practices (the attached pages 3-6).**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or legal representative)

# Authorization for Release of Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Hometown Physician Services / Medical Records  
 d  
 M  
 Email: Enrollment@hometownphysicianservices.com  
 Fax: 715-997-7044

Provider Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 FAX: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

**Information to be released**

**IMPORTANT:** d r r r r d

Specific dates / years of treatment: \_\_\_\_\_

**ALL HEALTH INFORMATION**

OR indicate portions of health information to be released:

<input type="checkbox"/> History / Physical	<input type="checkbox"/> Surgical Report	<input type="checkbox"/> Care Plan
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Medications	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Other Information / Instructions: d		

\_\_\_\_\_ r r r d d M

\_\_\_\_\_ r rd r r r d

Chemical dependency program

Psychotherapy notes (this cannot be combined with any other area listed above)

**MANDATORY:** Name of professional releasing psychotherapy notes:

Health information includes written and oral information r r r d d d

r d r d r r d r d r r r

r d r d r d d dr r rd d r d r

r d dr r

dr d r r dr d r r r r r

r dr d r r r dr d r r d r d

r r

**This consent will end one year from the date the form is signed unless I indication and early date or event here:** \_\_\_\_\_

**Patient or Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Legal Rep., Printed Name and Relationship to Patient:** \_\_\_\_\_

**Medical POA or Health Care Directive documentation must be included if signing on behalf of patient.**

# Hometown Physician Services

## Patient HIPAA Acknowledgement, Consent for Services and Insurance

### NOTICE OF PRIVACY PRACTICES

Hometown's  
d r d  
r r r r d d r d r  
r r r r r r r r  
r d r d r r d  
r r d r d r r r  
r r d r d r r r  
r r r r r r r r

### RELEASE OF INFORMATION:

r r r d  
r r r d r r r r  
r r r r r r r  
d d r r r r r d r d  
r d r r d r

### INSURANCE ASSIGNMENT PAYMENT CONSENT

r r r d r d r r  
r r rd r d r  
d r d r r r r r r  
M r r M d r r r  
r r r r r r d r d  
r r r r r r d d r  
r d r rd r r dd r  
r r d rr r r  
r r r r

### PATIENT CENTERED MEDICAL HOME CHRONIC CARE MANAGEMENT

r r r  
r r r r r r r d r  
d r d d r  
d r d d d d  
r rd r r d  
d r r r r r  
r r r r  
r r r d r r d  
r d r d

# Hometown Physician Services

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

information. "Protected health information" is information about

### **Uses and Disclosures of Protected Health Information**

the physician's practice, and any other use required by law.

**Treatment:**

**Payment**

**Healthcare Operations**

of your physician's practice.

Security: Workers' Compensation: Inmates: Required Uses and Disclosures:

## **Other Permitted and Required Uses and Disclosures**

### **You may revoke this authorization**

ian's practice has taken an action in reliance on the use or disclosure

## **Your Rights**

### **You have the right to inspect and copy your protected health information**

A "Designated Record Set" is the HIPAA term for medical

### **You have the right to request a restriction of your health information.**

"out pocket" in full.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this Notice from us**

**You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete**

## **Complaints**

## **Contact Us**

**Email:** \_\_\_\_\_

**Fax:**

**Phone:**

**Mailing Address    Hometown Physician Services**