K PRIMARY CARE & MEDICAL NUTRITION CENTER

Patient Registration Form

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employment Information

Employer: _____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

Student Status: ☐ Full Time Student ☐ Part Time Student

Emergency Contact Information

Emergency Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Insurance Information

PRIMARY CARRIER: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Responsible Party Information

Name: _____ Relationship to You: _____

DOB: _____

Address: _____

Phone: _____

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Electronic Communications

We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate, my email is provided below.

Home Email: _____

☐ No, I do not wish to participate at this time.

As an added convenience, we offer appointment reminders via a text message for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

☐ Yes, I want to participate, my cell number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate at this time. I would prefer to be notified by:

☐ Mail ☐ Telephone ☐ E-mail (via the Portal – you will need to participate, see above.)

Additional Optional Information

Race: Which category best describes your racial background?

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Unreported/Refused to Report

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site ☐ ER/Hospital

☐ Newspaper/Magazine ☐ Patient _____ ☐ Other _____

Pharmacy Information

Local Pharmacy Name: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Mail Order Pharmacy Name:

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

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Assignment of Benefits and Release of Information

I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance (if any) be made directly **to K Primary Care & Medical Nutrition Center** for services furnished to me or my dependent (Assignment of Benefits). I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize **K Primary Care & Medical Nutrition Center** to disclose any and all written information to my insurance company and/or its designated representatives, at the determination of **K Primary Care & Medical Nutrition Center**. Such disclosure shall be for reimbursement purposes for those services received. I hereby release **K Primary Care & Medical Nutrition Center**, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives. By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless my insurance company(s) or their designated representatives request records or information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist **K Primary Care & Medical Nutrition Center** or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof.
4. A firm contracted by **K Primary Care & Medical Nutrition Center** to perform billing or collections may use this authorization for billing and collections purposes.
5. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.

SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**