HIGHPOINT
FAMILY PRACTICE

HighPoint Family Practice, LLC

Registration Form

Patient Information-Please Print Clearly

Patient's Name _____ SS# ___-___-___ Birth Date ___/___/___ Age_____

Spouse _____ Guardian's Name if Minor_____
Street Address _____ City _____ State ____ Zip Code_____
Phone: Home _____-_____-_____ Work _____-_____-_____ Cell _____-_____-_____
Referred by: _____ Marital status_____ Email Address: _____
Patient's Employer _____ Occupation (Indicate if student) _____
Employer's Address _____ City/State _____ Zip Code_____

In case of emergency:

Notify _____ Relationship _____ Phone #_____

Pharmacy _____ Location _____ Phone #_____

Insurance Information

1. Primary Insurance company_____Policy#_____
- ☐ Policy Holder's Name_____
- ☐ Insurance Policy Holder's Employer_____
- ☐ Policy Holder's Relation to Patient_____
- ☐ Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SSN _____-_____-_____

2. Secondary Insurance Company_____ Policy #_____
- ☐ Policy Holder's Name_____
- ☐ Insurance Policy Holder's Employer_____
- ☐ Policy Holder's Relation to Patient_____
- ☐ Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SSN _____-_____-_____

Consent to Share:

I, _____ DOB_____, hereby give permission to HighPoint Family Practice, LLC to release any and all results to the person or persons listed below.
Relationship _____,_____ Phone #_____

We require all patients to show their insurance or managed care membership card and their driver's license so that we may make copies for our permanent records.

We cannot render services on the assumption that our charges will be paid by an insurance company. If no proof of insurance is presented at time of service, all services will be charged directly to the patient and her or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collection to the patient's account.

Payment and Release of Information Authorization

I,_____, hereby authorize HighPoint Family Practice, LLC, to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the practice all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and/or attorney fees associated with my failure to pay my debt. A photo static copy of this authorization will be valid as the original. I hereby authorize HighPoint Family Practice, LLC to release the medical information obtained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary. I acknowledge and agree that I may be evaluated and treated by a Registered Nurse Practitioner.

I understand that, if a lab test is performed on me at HighPoint Family Practice, or if a test is done per an outside facility, my insurance will be billed by the outside facility for services rendered. If my insurance fails to pay, I understand I am responsible for the charges due to the facility assisting in my care.

Signature of Patient (Guardian) _____Date ___/___/_____

HighPoint Family Practice, LLC

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services, we have developed this payment policy. Please read it, ask us questions you may have, and sign in the space the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefit is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You may pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information from before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help your receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our provider will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge $25 for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

HighPoint Family Practice, LLC

Consent for Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending provider (s), or any other healthcare professional assigned to my care by my attending healthcare provider, and I acknowledge and consent to the following:

1. INDEPENDENT CONTRACTORS: HighPoint Family Practice, LLC may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of HighPoint Family Practice, and are responsible for their own actions. I understand that HighPoint Family Practice LLC shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my providers.

2.During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my provider (s) to provide me with additional information. I also understand my healthcare provider may ask me to sign additional Informed Consent documents related to specific procedures.

3.I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

4.VALUABLES: HighPoint Family Practice, LLC assumes no responsibility for, and I hereby release HighPoint Family Practice, LLC from liability for, loss or damage to any to any of my personal property while on the premises and/or receiving treatment.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).
A copy of this document may be utilized the same as the original.

_____ Date:_____
Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____

HighPoint Family Practice, LLC 886 Hampton Rd., McDonough GA, 30253, 678-583-8388, Fax 678-583-8389

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for HighPoint Family Practice, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by HighPoint Family Practice, LLC describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at HighPoint Family Practice, LLC).

I have the right to review the Notice of Privacy Practices prior to signing this consent. HighPoint Family Practice, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request.

With this consent, HighPoint Family Practice, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, HighPoint Family Practice, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

With this consent, HighPoint Family Practice, LLC may email to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow HighPoint Family Practice, LLC to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, HighPoint Family Practice, LLC may decline to provide treatment to me.

Signed by:_____ _____ _____
Signature of Patient or Legal Guardian Date Relationship to Patient

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Acknowledgement of Notices of Privacy Practices:

I have been present with a copy of the notice of Privacy Practices for the office of Wendy Parrish, APRN, FNP-C. detailing how my information may be used and disclosed as permitted under federal and state law.

Signed:_____ Date:_____
If not signed by patient, please indicate relationship to patient (e.g. mother) and patient's name.

Patient_____ Relationship_____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of insured) (Name of Insurance Company)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to me for his/her
(Provider's Name)

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____
(Provider's Name)

will be credited to my account, in accordance with the above said assignment

_____ _____
(Authorized Signature of Subscriber) (Date)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to HighPoint Family Practice for any services furnished to me by APC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the healthcare provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non –covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

Financial Policy

I have read and understand the financial policies of HighPoint Family Practice. By my signature I agree to the terms outlined in the financial policy.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize HighPoint Family Practice to provide medical care reasonable by today's standards.

_____ _____
Signature of Patient/Legal Guardian Date

HIGHPOINT
FAMILY PRACTICE

HighPoint Family Practice, LLC (www.highpoint12.com)

Patient History and Physical Form

Name _____ DOB: _____ Age _____ Date: _____

Address: _____ Occupation _____

Phone: Cell _____ Home _____ Work _____

Reason for visit: _____ Pharmacy_____

Past Medical History

• High Blood Pressure • Congested Heart Failure • Pacemaker • Atrial Fib • Heart Murmur • Kidney Disease • Gout • Allergies/Sinus problems • Asthma/Emphysema • Bronchitis	• Pneumonia • Stomach ulcer • Reflux disease • Crohns Disease • Gallbladder Disease • Prostate Problems • Fibroids/Ovarian Cyst • Venereal Disease	• Diabetes • Hepatitis • Anemia • Arthritis • Osteoporosis • Thyroid Problems • Depression • Anxiety Disorder • Stroke • Cancer: Type	• Glaucoma • High Cholesterol • Epilepsy/Seizures • Kidney Stones • Blood Clots • Migraine Headache • Trouble Sleeping • Sleep Apnea • Snoring • _____

Hospitalizations/Surgeries/Screenings

Reason	Date	Screenings:	Date	Results
		Colonoscopy		
		Mammogram		
		Pap Smear		
		Prostate Exam		
		Bone Density Test		

Women only: Pregnant Y N LMP **Contraceptive Method:**

Drug/Food Allergies

_____
_____
_____
_____
_____

Medication/Dosage/How often do you take?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Family History

	Father	Mother	Father's Parent	Mother's Parent	Brother	Sister
Heart Disease						
High Blood Pressure						
Stroke						
Stomach Problem						
Diabetes						
Cholesterol						
Epilepsy/Seizures						
Blood Clots						
Kidney Disease						
Thyroid Disease						
Anxiety/Depression						
Osteoporosis						
Cancer						

Do you Smoke? Y N How many packs per day? _____ #of years _____

If no, have you ever smoked? Y N How many packs per day? _____ When did you quit? _____

Any Alcohol use? Y N If so: Alcohol Beer Wine How many drinks per day? _____

Caffeine: (cups per day) Coffee: _____ Tea _____ Energy Drinks _____

Do you Exercise? Y N How many times per week? _____ Minutes per day? _____ Aerobics, Weight lifting, Cycling, walking _____