ENCORE
MEDICAL SPA &
FAMILY MEDICINE

Patient Registration Form (*Print Only In Black Ink)* **Phone: 256-273-6827** **Fax: 256-273-6828**

Last Name:	**First Name:** **M.I.:**	**Previous Name (if applicable):**
Mailing Address:		**Apt #:**
City/State/Zip:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Preferred Method of Contact for Reminder Call & Other Electronically Generated Message: (Please Select Only One Option) [] Voice [] Text		**If Voice, Please Select Preferred Number: [] Home [] Cell [] Work**
Date of Birth:	**Sex: [] Male [] Female**	**Marital Status:**
Family Physician or Pediatrician:		

Employer Name:	**Emergency Contact Name:**
Emergency Contact #:	**Relationship to Patient:**

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	**First Name:**
Date of Birth:	**Phone:**
Address of Person Responsible:	
City/State/Zip:	**Relationship to Patient:**

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	**Can we leave a message regarding your medical care and test results? [] Yes []No**
Race (please select): **[]White []American Indian or Alaska Native []Asian [] Hispanic []Black or African American []Native Hawaiian or Pacific Islander []Other []Decline**	**Ethnicity (please select one):** **[] Hispanic or Latino** **[] Not Hispanic or Latino** **[]Decline**

Preferred Language (please select one):
[] English [] Spanish []Bosnian [] Indian (including Hindi and Tami) [] Sign Language [] Russian [] Other

Preferred Pharmacy Name and Location:

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	**Ins. Co. Name**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder's DOB:	**Policy Holder's DOB:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

I certify that I have read and agree to Encore Medical Spa & Family Medicine payment policy. I am eligible for the Insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Encore Medical Spa & Family Medicine all money to which I am entitled for medical expenses related to the services performed from time to time by Encore Medical Spa & Family Medicine, but not to exceed my indebtedness to Encore Medical Spa & Family Medicine. I authorize Encore Medical Spa & Family Medicine to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $35.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications EMSAFM by text or e-mails at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they will be read by a third party.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to EMSAFM. I authorize any holder of medical information about me to release to CMS and its agents my information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party x_____ Date: _____

Printed Name of Responsible Party x_____ Date: _____

CONSENT TO TREAT FORM

I, the undersigned, hereby consent, for myself, or a minor child to whom I have authority to sign, to outpatient care from Encore Medical Spa and Family Medicine. This involves encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications, as ordered by a provider. This consent includes my permission for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the director of a physician, as deemed reasonable and necessary. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/ or any body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself or the minor in which I represent to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Encore Medical Spa and Family Medicine Notice of Privacy Practices.

I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

NAME	**RELATIONSHIP**

I hereby give my consent to treat the minor child below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Encore Medical Spa and Family Medicine.

For patients 16 -18 yrs of age only:
Any care deemed medically necessary may be provided without my presence. [] Yes [] No

Signature of Legal Guardian: _____ Relationship: _____
Date: ____/_____/_____

----------OR----------

I authorize Dr. Sherrill or any Encore Medical Spa and Family Medicine provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I do not authorize that my child be treated in my absence. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.
Signature: _____ Relationship: _____
Date: ____/____/___

FOR ADULTS 18 & OLDER:

I hereby give my consent to Dr. Sherrill or any other provider of Encore Medical Spa and Family Medicine to provide medical care for me.
Signature: _____ Date: _____/_____/_____

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PRIVACY & CONFIDENTIALITY NOTICE ACKNOWLEDGMENT

I understand that protected health information may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the Encore Medical Spa and Family Medicine Privacy Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time.

This office reserves the right to amend the privacy policy whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

I authorize this office to leave messages on my answering machine regarding protected health information:
[ ] Yes [ ] No

DESIGNATED PARTY AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (OPTIONAL)

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records.

This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

1. Designated Party: _____ Tel: _____
   Relation:_____

Should this person also be able to make inquiries about or pay balances on my account? [ ] Yes [ ] No

2. Designated Party: _____ Tel: _____
   Relation:_____

Should this person also be able to make inquiries about or pay balances on my account? [ ] Yes [ ] No

3. Any medical care and/or laboratory services deemed necessary to my continuation of care as directed by my Encore Medical Spa and Family Medicine Provider is allowed to be shared with the designated person(s) .
   [ ] Yes [ ] No

Signature: _____ Date: ____/_____/_____

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Authorization to Obtain Medical Information

Patient Name: _____ DOB: ____/____/____

I, _____hereby authorize the release of medical information

To:

Encore Medical Spa and Family Medicine **Address:** 1202 Gault Ave North, Fort Payne, Al 35967

From:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Please release the following:

[] All health information (including growth charts and vaccination records)

[] History/ Physical Exam	[] Diagnostic Test
[] Progress Notes	[] Radiological test or Imaging test
[] Discharge Summary	[] Lab Report
[] Consultation Reports	[] Pathological test

[] Other (specify): _____

I also consent to specific release of the following records:

[] Drug/Alcohol/Substance abuse	[] Psychiatric/ Mental Health
[] Test for antibodies to HIV	[] Diagnosis & Treatment Genetic Information

Purpose of disclosure: [] Treatment/ Ongoing medical care [] Coordination of care

REVOCATION: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Otherwise, this authorization shall remain valid for 1 year from the day on which it is signed. I authorize transmission of my health records in situations where this information is needed for continuing care.

A photocopy or facsimile of this authorization shall be considered as effective as valid as the original. I have been advised on my right to receive a copy of this authorization.

Signature: _____ Date: _____/_____/_____

Print Name: _____ Relationship to Patient: _____

Witness Name: _____ Witness Signature: _____

***Please fax records to 256-273-6828 or mail them to the address above. If you have any questions, please call us at 256-273-6827.**

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Financial and Privacy Policy

Thank you for choosing Encore Medical Spa and Family Medicine as your Healthcare Provider. The following guidelines have been established to help you understand our expectations for our services.

Assignment of Benefits (by signing this you state that)

I hereby assign and authorize payment directly to Encore Medical Spa and Family Medicine all benefits payable under the terms of any insurance policy if insurance is filed by this office. I realize the insurance benefits may not pay the entire bill and agree to pay the difference or the entire bill if necessary. I authorize the release of any medical and medication information necessary to process my insurance claims or to continue my medical care.

Payment in Full

You are responsible for your co-pay, any unmet deductibles, and "co-insurance" that your insurance plan considers your responsibility at the time of your visit. We gladly accept cash, checks, and most credit cards.

Insurance Claims

As a courtesy to our patients, we will file your primary and secondary insurance claims. In order for us to provide this service, we need to copy your most current insurance card and a picture ID. Any payment from your insurance company will come to Encore Medical Spa and Family Medicine for our services when we file for you. Please remember that insurance coverage is a contract between the patient and the insurance company; therefore, any payments or deductibles are due at the time of your appointment. You will be responsible for any non-covered services. If your insurance payment is not received within 60 (sixty) days, the balance will automatically be assigned to you for payment and will be due immediately.

Usual and Customary Reimbursement

Our charges (fees) have been set to accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that our fees reflect what is usual and customary. If your insurance company's fee schedule falls below the level of charge, you will be responsible for payment in full (unless we have a written contract with your insurance company).

Self-Pay

You are required to pay in full when services are rendered if you have no insurance. Any payment arrangements must be made prior to seeing the physician.

Collection Policy

If your account becomes delinquent, and sent to an outside agency or attorney for collection you will be responsible for all costs, including agency fees, attorney fees, court costs, and any other related expenses. Your account will be changed to a "cash only" status and prepayment prior to service will be required. You agree and waive all rights to claim personal property exempt under the laws of the state of Alabama.

Missed Appointments

If you miss more than one appointment (without rescheduling in advance) you will be charged a $20 "No Show" fee that must be paid prior to coming in for a new visit. This fee is $50 for in office procedures.

HIPAA

I acknowledge that I have been offered and received a copy of the HIPAA policy.

If you have any questions regarding the financial and HIPAA policy, it will be our pleasure to answer them for you.

Signature X_____

Date____/_____/_____

Receipt of Notice of Privacy

I, _____, have received a copy of Encore Medical Spa & Family Medicine, Notice of Privacy Practices.

Signature of Patient or Legal Guardian:

_____

Date Signed_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Policies, but acknowledgment could be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtained the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (specify)

_____