TMB MEDICAL ASSOCIATES PC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

□ Dr. □ Mr. □ Mrs. □ Ms. □ Jr. □ Sr. □ Other ________________ Male _____ Female ____

Patient's Name : (Last) __________________________ First ___________________________ Middle ____________________

Address : ____

City, State, Zip ____

SS # _________________________________ DOB : ____________________ E-mail address: ________________________________

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____ Legally Separated ______ Other _____

Phone Numbers: Home _______________________ Cell ________________________ Work ________________________

Employment Status: Employed _____ Student _____ Retired _____ Self Employed ______ Unemployed ______

Employer: ______________________________________ Occupation: ____

Employer address : ____ City : ____________________________ State ________

Emergency Contact: ____________________________________ Phone # _________________________ Relationship _______________

How did you hear about us? ______________________________ Preferred Pharmacy : _____________________________________

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Responsible Party Name: (Last) ____________________________ (First) _________________________ (Middle) ________________

Address : ____ City: ______________________ State: ______ Zip: ___________

SS # ______________________________ DOB : ________________ Relationship to Patient : _________________________

Phone Numbers: Home _______________________ Cell ________________________ Work ________________________

Employer: ____

Employer address : ____ City : ____________________________ State ________

PRIMARY INSURANCE INFORMATION:

Name of Insured: ____ Relationship to Patient _____________________

Insured Employer Name: ______________________________________ Insurance Company Name: _________________________

Subscriber ID (Policy Number) ___________________________ Group ID _________________ Co-pay amount $ __________

Insured DOB: _________________________ Insured's Social Security Number _____________________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ____ Relationship to Patient _____________________

Insured Employer Name: ______________________________________ Insurance Company Name: _________________________

Subscriber ID (Policy Number) ___________________________ Group ID _________________ Co-pay amount $ __________

Insured DOB: _________________________ Insured's Social Security Number _____________________________

PLEASE NOTE: OUR OFFICE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD OR YOU WILL BE EXPECTED TO PAY IN FULL AT TIME OF SERVICE.

Patient Name: ___________________________ Date: _____________

OFFICE POLICIES

SCHEDULING APPOINTMENTS
Our front office staff may need to question you as to the reasons you need to be seen in order to give you an accurate appointment length. Please answer them accurately to help us keep our physicians' schedules running on time and to minimize wait times.

If you are more than 15 minutes late for an appointment, you may be asked to reschedule

Initials ________

MISSED APPOINTMENTS
Our office does charge a fee for missed appointments without a phone call to cancel at least 24 hours before your appointment time. If you are charged, this must be paid in full prior to being seen again in our office

Initials ______

PRESCRIPTION REFILLS

- If you get your prescriptions filled at a pharmacy, **PLEASE USE THE PATIENT PORTAL OR CALL YOUR PHARMACY FIRST** with your refill request (they will fax us your order)
- Please allow 3 days for prescription requests to be processed
- DO NOT WAIT UNTIL YOU ARE OUT OF MEDICATION TO CALL.
- If you have an appointment with us, that is the BEST TIME to discuss refills.

Initials _____

RETURNED CHECKS
All returned checks will incur a $30 billing fee. The patient will be responsible to pay this in full before being seen again in our office

Initials ______

LAB/TEST RESULTS
If you have not heard from our office within 3 weeks of having your labs drawn or test done, please call our office. Initials __________

1181 Langford Drive Bldg 200 Ste 105
Phone: 706-548-9655 Fax: 706-548-9672

TMB MEDICAL ASSOCIATES, PC

FINANCIAL POLICIES

It is the policy of this office to pay for services in full when rendered. If this applies to you, we will file your claim and you will be expected to pay what the insurance company does not pay. In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal Guarantee of payment for all charges herein, incurred. If this account is placed with an attorney for collection, the undersigned parties agree to pay all reasonable attorney fees, as well as costs of collection. I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of the claim.

Patient, Parent, or Guardian ______________________________ Relationship to Patient ___________________ Date __________

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. The privacy notice describes our privacy practices, specifically how we use and disclose your medical information and what right you have with respect to this information. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you have received this notice. By signing below, you are acknowledging that you have received a copy of or have had access to a copy of our Privacy Statement.

Initials : ________ Signature : ____ Date: ______________

HIPAA PRIVACY RULE

Please list the parties to whom you authorize TMB Medical Associates PC to disclose your protected health information

Name: ____________________________________ Relationship: ______________________

Name: ____________________________________ Relationship: ______________________

Name: ____________________________________ Relationship: ______________________

PHOTO AUTHORIZATION

I authorize TMB Medical Associates, PC to use my photo as part of my protected health record for identification and treatment purposes only.

Patient, Parent, or Guardian ________________________________ Relationship _________________ Date :__________

1181 Langford Drive
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706-548-9655