Patient Registration Form

Physician Name: ___________________________________

Patient Name: _______________________________________ Social Security Number: ______-_______-_______

Date of Birth: _____/_____/_______ Sex: M/F (Circle one) Married/ Single/ Divorced/ Widow

Address:____

Race: _______________ Religion: ___________________ Primary Language:______________________________

Home Phone: (_____) ______-______ Work: (______) _______-_______ Cell phone: (______) _______-_______

Primary Phone: (______) ______-_______ **Email Address**: ____

How would you like to receive notifications from our office? ____

How did you hear about our Practice? ____

Employer Name and Contact Number: ____

Preferred Pharmacy:

Pharmacy Name: _______________________________ Address: ____

Insurance Information:

Insurance Company:____________________ Policy Number: ________________ Group Number ________________

Policy Holder: ______________________________ Date of Birth: ______/_______/_______

Guarantor Name: ___________________________ Social Security Number : ________-________-_________

Relationship to Patient: (Please check): ( ) Self, ( ) Spouse, or ( ) Parent

Secondary Insurance: ____

Policy Number: ________________________________ Group Number: ________________________________

Policy Holder Date of Birth: _____/______/_______

Guarantor Name: _______________________________ Social Security Number: ______- _______-________

Relationship to Patient: (Please check): ( ) Self, ( ) Spouse, or ( ) Parent

Emergency Contact:

Name: __________________________________ Address :____

Home Phone: (______) ______- _______ Work Phone: (_____) ______-______ Relationship:_____________________

I authorize assignment of insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim. I hereby consent to such diagnostic procedures and treatment deemed necessary or advisable by my physician.

Patient Signature: ____

Parent or Guardian Signature: __________________________________ Date: ______/______/_______

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Patient Consent Forms

Notice of Privacy Practices and Financial Disclosure

Acknowledgement of Receipt

I, _______________________________, hereby acknowledge that I have received a copy, a detailed copy of the company's Privacy Practices Notice.

Patient/ Guarantor Signature: ____ **Date:** _____/_____/______

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Consent to Release Information:

In the event I cannot be reached, I, _________________________ (Your name), give permission for a representative from Concierge Medicine of Columbus, Elite Family Medicine and Dr. Susan Westerlund's office, to speak with a family member(s) or companion (s) listed below regarding care or test results.

Name: ______________________________ Phone: (_____) ______-_______ Relationship : ____________________

Name: ______________________________ Phone: (_____) ______- _______ Relationship: ____________________

Financial Disclosure:

______ I understand that I am responsible for all co-payments, coinsurance amounts and deductibles. All co-payments, coinsurance amounts, and deductibles are due at time of service. Additional payment may be required based on your individual insurance plan.

No show Policy and Procedure

Initial Below:

_______ In the event you are unable to keep your appointment, please reschedule at least 24 hours in advance. Failure to notify our office within 24 hours may result in a no-show fee of $45.00 for primary care and $50.00 for specialist.

_______ A $54 fee will be incurred for returned checks

After hours Telephone Advice

_______ Calls received after office hours in reference to medical advice and/ or treatment given over the phone will be charged a fee from $25.00- $45.00.

_______ If you call the office during regular office hours and are treated over the phone you may be charged for these services. Charges can range from $25.00- $50.00. This fee is not reimbursable by insurance.

_______ If patients have forms to be completed, there will be a charge. Charges can range from $25.00 to $50.00 depending on the type of medical form.

By signing below, I indicate my understanding of the above clinic policy and procedures.

Patient/ Guarantor Signature: ____ **Date:** ______/_______/_______

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

E-Prescribing Consent Form

E- Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to the pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E- Prescribing greatly reduced medication errors and enhances patient safety.

The Medical Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Formulary and benefit transactions- gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions- provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patients has been picked up, not picked up, or partially filled.
- By signing this consent form, you are agreeing that your attending physician can request and use our prescription medication history from other healthcare providers and/ or third-party pharmacy benefit payers for treatment purposes.
- Understanding all the above, I hereby provide informed consent to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name: ___________________________________

Date of Birth: ______________________

Signature of Patient or Guardian Relationship: ____

The Patient Health Questionaire-2 (PHQ-2)

Patient Name ______________________________________ **Date of visit** _____________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Adapted from the patient health questionnaire (PHQ) Screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.