One World HEALTHCARE

# New Patient Registration Form

Copay $ ______

## General Information (please print)

Name: ____________________ DOB ____________ Sex: __M __F

Social sec # ______________ Marital status: Single___ Married___ Divorced ___Widowed ___

Primary address ______________________________

City ____________________ State __________ Zip __________

Home phone ____________Work phone ____________ Cell phone ____________

Emergency contact ____________ Relationship ____________ Phone ____________

E-mail ______________________________ Authorize E-mail? ___Y ___N

Pharmacy name ____________________ Phone ____________ Fax ____________

Employment status: ___employed ___not employed ___retired ___student

Employer: ____________________ Occupation ____________________

## Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES ________ NO ________ (initial yes or no)
- Leave a detailed message with individual answering the phone YES ________ NO ________ (initial yes or no)

## Sharing of Medical Information

I give the physician and office staff of OWH permission to discuss my medical condition with the following individuals:

Name:______________________________ Relationship:______________

Name:______________________________ Relationship:______________

Name:______________________________ Relationship:______________

## Doctor Information

Referring Physician ______________________ Specialty ______________

Primary Care Physician ______________________ Phone ______________

## Primary Insurance

Insurance name ______________________ Subscriber's name ______________

Insurance ID#: ______________________________

Social Sec # ______________ DOB __________ Relationship to insured ______________

## Secondary Insurance

Insurance name ______________________ Subscriber's name ______________

Insurance ID#: ______________________________

Social Sec # ______________ DOB __________ Relationship to insured ______________

## Patient Authorization for ePRESCRIBE

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of OWH to enroll me in the ePrescribe Program. .

Patient signature ______________________________ Date ____________________

## Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of OWH to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient signature ______________________________ Date ____________________

## Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of OWH to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature ______________________________ Date ____________________

## Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of OWH to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to One World Healthcare the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature ______________________________ Date ____________________

## Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and OWH to photograph me for medically related documentation purposes.

Patient signature ______________________________ Date ____________________

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish***. I acknowledge that I have received a copy of the OWH'S Notice of Privacy Practices.***

| ____________________ | ____________________ | ____________ |
|---|---|---|
| Printed name | Signature | Date signed |