New Patient Registration Form

Name: _____ DOB _____ Sex: __M __F

Social sec # _____ Marital status: Single____ Married____ Divorced ____Widowed ____

Primary address _____ City _____ State _____ Zip _____

Home phone _____Work phone _____ Cell phone _____

E-mail _____ Authorize E-mail? ____Y ____N

Pharmacy name _____Phone _____ Fax _____

Employment status: ____employed ____not employed ____retired____student

Employer: _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

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 voicemail/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:_____

Patient Authorization for ePRESCRIBE

ePrescribing 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 payers 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.***

_____
Date_____
Printed name

_____
Signature
!

Office Policies

Patient name: _____ DOB: _____

Appointments:

1. If you arrive 10 minutes late to your appointment, we reserve the right to reschedule your appointment.
2. The office will allow 3 no shows or late cancellations. We will provide emergency care only for 30 days to allow you time to find a new provider.
3. 24-hour notice is required to cancel appointments. Same day cancellations and missed appointments will result in a $50.00 fee. We do understand that conflicts may occur, however, the more notice we receive, the better we can serve other patients in their need of medical care.

Financial Agreement:

1. **NOTE**: Payment in full is required at the time services are rendered. It is your responsibility to know your coverage and confirm that your insurance is active. *We accept cash, checks (under $50), Visa, Master Card, Discover, and American Express.*
2. For preventive visits, please know that you will be responsible for copayment regarding any acute visit outside of what is included in the preventive visit.
3. A fee of $50 will be charged for any returned checks.
4. If there is a balance on your account, you are responsible for paying 80% of the balance before being seen.
5. There will be a $75.00 fee for form(s) that require the providers to fill out. (FMLA, work and school forms)
6. MEDICARE patients: please sign an ABN form before being seen.

Media

★ Cameras and cell phones are allowed ONLY in the waiting area. However, video recording and photography are strictly prohibited.

_____ _____

Patient signature Date

_____

Staff signature

One World HEALTHCARE
5500 Knoll North Drive ■ Columbia, MD 21045
www.one-world-healthcare.com
410-730-7040

Authorization for Release of Medical Records

Patient Name:_____ Date of Birth: ____/____/____

Information to be released

____ Complete medical records ____ Laboratory report only. _____ Exclude: _____
____ Radiology Report only ____ Other: _____

Information to be excluded

I understand that this authorization includes permission to release any PHI in my health record relating to the history, diagnosis, testing/results, or treatment that I may have received for sexually transmitted disease (STD), acquired immunodeficiency virus (HIV), behavioral or mental health services, or treatment of alcohol, drug or substance abuse.

Records to be released for the purpose of

_____ Changing provider _____ School. _____ Consultation or Second opinion
_____ Insurance _____ Legal _____ other: _____

I hereby authorize _____ to release the protected health information (PHI) to One World Healthcare for the identified dates of service from dates: ____/____/____ to ____/____/____.

Released From

Organization: _____
Street: _____ City: _____ State: _____ Zip:_____
Phone:_____ Fax: _____

By signing this Release of Information form, I understand that

1. I have the right to revoke this form at any time and it must be made in writing to:
   One World Healthcare
   5500 Knoll North Drive, suite 220
   Columbia, MD 21045
   410-730-7040 phone/844-890-8427 fax
2. Revoking this form does not apply to records or information that has already been authorized and disclosed.
3. This authorization will expire one year from the date signed, unless it has been revoked.
4. Request for records will be subject to copying and preparation fees in accordance to MD federal and state law regulations.

I hereby authorize One World Healthcare to release the PHI listed above from the medical records.

_____ _____ _____

Patient signature ***Relationship if anyone other than patient*** ***Date***