DR. ANDY HIGGINS
PATIENT REGISTRATION FORM

PATIENT NAME____BIRTHDATE______/______/_____

(LAST) (FIRST) (MI)

AGE______________ SS#_______________________________ EMAIL____

MAILING ADDRESS____CITY________________________STATE__________ZIP______________

STREET ADDRESS____CITY________________________STATE__________ZIP______________

HOME PHONE (______) ________-___________ MAY WE LEAVE A DETAILED MESSAGE? YES________NO________

CELL PHONE (_______) _________-___________MAY WE LEAVE A DETAILED MESSAGE? YES________NO________

EMPLOYER__________________________________WORK # (______) _______-_______OCCUPATION____

EMERGENCY CONTACT PERSON____________________________ (______) _______-________RELATIONSHIP_________________________________

PRIMARY CARE PHYSICIAN____REFERRING PHYSICIAN____

PHARMACY____PHARMACY LOCATION____

RESPONSIBLE PARTY (IF MINOR) ____BIRTHDAY_______/______/_______

MAILING ADRESS____CITY__________________________STATE___________ZIP_____________

PHONE (_______) _________-__________RELATIONSHIP TO PATIENT________________________________ SS#_________________________________

PRIMARY INSRUANCE CARRIER____ID#____________________________GRP#____________________

NAME OF INSURED____BIRTHDAY______/______/_______

SECONDARY INSURANCE CARRIER____ID#______________________________GRP#____________________

NAME OF INSURED____BIRTHDAY_____/_______/_______

*****THIS SECTION REQUIRED BY CENTERS FOR MEDICARE & MEDICAID SERVICES FOR ELECTRONIC HEALTH RECORD REPORTING*****

RACE (CHECK ONE)

- American Indian or Alaska Native
- Asian
- Native Hawaiian/Pacific Islander
- Black or African American
- White
- Other__________________________
- REFUSED

ETHNICITY (CHECK ONE)

- Hispanic/Latino
- Non-Hispanic/Non-Latino
- REFUSED

PREFERRED LANGUAGE (CHECK ONE)

- English
- Spanish
- Other__________________________
- REFUSED

The above information is true to the best of my knowledge.

____ ____

RESPONSIBLE PARTY SIGNATURE DATE

HIPAA Privacy Act

My health information may include both created and received documents by **Dr. Andy Higgins** and may be in the form of written or electronic records, or spoken words. My record may include information of my health history, health status, test results, diagnosis, treatments, procedures, prescriptions and similar types of health related information.

I understand that I have the right to receive and review a written description of how **Dr. Andy Higgins** will handle my health information. This written description is known as **a Notice of Privacy Practices** and describes the uses and personnel of **Dr. Andy Higgins** and my right regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also, understand that a copy or summary of the most current version of Dr. Andy Higgins' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

By signing, I agree that I have reviewed and understand the information above and that I have been offered/received a copy of the Notice of Privacy Practices.

Patient's Signature: ____Date:_______________________

Special Permission Request

Initial_________ I give my permission for Dr. Andy Higgins and/or his staff to leave a message regarding appointments on my voice mail.

Initial________ I give my permission to have messages regarding treatment, billing, and/or appointment status left with my spouse/partner/caregiver:____

Name of spouse/partner/caregiver

Initial_________ This release will be revoked by written permission only. I understand that I must send a written request to Dr. Andy Higgins in order to revoke this release.

Do you have an Advanced Health Care Directive? Yes/No

If yes, is it on file with your Primary Care Provider? Yes/No

DR. ANDY HIGGINS
PATIENT REGISTRATION FORM

Patient Payment Policy

In the interest of good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

- A valid insurance card and a photo ID will be required at each visit.
- Your insurance coverage will be validated at each subsequent visit. It is the patient's responsibility to notify this office of any changes to your insurance coverage.
- It is the policy of Dr. Andy Higgins to collect all payments and co-payments due from patients at the time of service.
- Dr. Andy Higgins accepts the following forms of payment: Cash, checks, VISA, MasterCard and Discover.
- If you are scheduled for a procedure, our office will contact your insurance carrier to obtain pre-authorization, if required, on your behalf.
- Your insurance benefit is a contract between you and the insurance company. We are not a party to that contract.
- It is your responsibility to know the services covered by your insurance and if your insurance does not cover these services, you will be responsible for payment.
- Our office will review your insurance benefits with you and make an **estimation** of charges based upon the procedure(s) scheduled and information supplied by your insurance company. If additional or different procedure(s) are necessary, or insurance information is inaccurate, it will affect the final bill. Any **estimated** amounts not covered by your insurance (deductible, co-pay and/or co-insurance) will be collected prior to the day of surgery.*
- If you are unable to pay in full or you are without health insurance, please, contact the office to arrange a mutually acceptable payment plan prior to your office visit and/or procedure.*
- If your insurance company denies payment due to incorrect information you provided, non-covered service or benefit you will be billed and payment in full will be due immediately, or a mutually agreed upon payment schedule can be arranged.*
- In the event of an overpayment, a timely refund will be issued.
- If your account is sent to a collection agency for non-payment, you will be responsible for the collections agency fees and face possible dismissal from care.
- Any un-paid balance over 180 days will have a 9% monthly re-billing fee added to your balance owed, until your balance is paid in full.
- There will be a $25 charge for any returned checks to cover the cost of the associated bank charges.

INITIAL__________

____ ______________

Responsible Party Signature Date

*Extenuating circumstances will be considered.

PRACTICE POLICIES

PRESCRIPTION REFILLS

- Please contact your pharmacy for prescriptions refills.
- Refill requests can take up to 48 hours to be reviewed, so you will need to plan ahead and call your pharmacy several days prior to being out of your medication.
- Refill request(s) will only be honored during our regular business hours.
- **NARCOTIC PAIN MEDICATION REQUIRES A WRITTEN PRESCRIPTION AND CANNOT BE CALLED OR FAXED INTO A PHARMACY. YOU WILL HAVE TO PICK-UP THE PRESCRIPTION AT OUR OFFICE DURING REGULAR BUSINESS HOURS.**
- To check on the status of your refill request you must call your pharmacy for an update.

INITIAL______________

APPOINTMENTS

- For your initial consultation please arrive 15 minutes early to complete the registration process
- For subsequent visit please arrive 10 minutes early to complete the update process. INITIAL______________

MEDICAL RECORDS

We use an electronic medical record with a secure local host and a secure cloud- based backup. These medical records are the property of Dr. Andy Higgins; however, you are entitled to copies. Please note that we can only release records that originated from our office, we cannot release records from other doctor's offices that may be in our chart. If medical records are requested directly from another physician's office, they are sent directly to that office at no charge. If medical records are requested by a third-party such as an insurance company or an attorney's office, then the requesting party will be billed for the records. If you request a copy of your medical records, the first copy will be provided at no charge and subsequent copies at $0.25/page charge. Upon receipt of our signed Medical Records Release Form, records will be provided to you within the State-mandated 30 day period.

INITIAL______________

MEDICAL LEAVE PAPERWORK

- No fee will be charged for return-to-work letters or other employer-restriction notes.
- Please allow two weeks for completion, there will be no status updates earlier than 14 days.
- A $25 fee will be charged to complete each Family Medical Leave Act and Standard Disability form.

INITIAL_____________

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Responsible Party Signature Date