SUMMIT MEDICAL GROUP PATIENT REGISTRATION FORM

ACCOUNT #	DATE	PHYSICIAN NAME

PATIENT FIRST NAME	MIDDLE	LAST	BIRTH DATE	AGE

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK/BUSINESS PHONE #	E-MAIL ADDRESS

EMPLOYER NAME & ADDRESS

RACE	ETHNICITY	PRIMARY LANGUAGE	SEX	GENDER IDENTITY	SEXUAL ORIENTATION	MARITAL STATUS

PHARMACY OF CHOICE	PHARMACY PHONE #

HOW WERE YOU REFERRED TO SUMMIT MEDICAL GROUP?

HAVE YOU BEEN TREATED BY A SUMMIT MEDICAL GROUP PHYSICIAN BEFORE? ☐YES ☐NO	DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE? ☐YES ☐NO DO YOU HAVE A LIVING WILL? ☐YES ☐NO If yes, please provide a copy of the above document(s) to the office for your medical record.

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)

FIRST NAME	MIDDLE	LAST	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK/BUSINESS PHONE #	E-MAIL ADDRESS

EMPLOYER NAME & ADDRESS

EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)

NAME	EMERGENCY PHONE #	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME	EFFECTIVE DATE	INSURANCE NAME	EFFECTIVE DATE
INSURANCE ID	GROUP #	INSURANCE ID	GROUP #
CLAIMS ADDRESS		CLAIMS ADDRESS	
SUBSCRIBER ID #	GROUP #	SUBSCRIBER ID#	GROUP #
SUBSCRIBER NAME & ADDRESS		SUBSCRIBER NAME & ADDRESS	
SUBSCRIBER BIRTHDATE		SUBSCRIBER BIRTHDATE	
SUBSCRIBER SSN #	RELATIONSHIP TO PATIENT	SUBSCRIBER SSN #	RELATIONSHIP TO PATIENT
EMPLOYER NAME, ADDRESS, & PHONE		EMPLOYER NAME, ADDRESS, & PHONE	

FOR PRESCRIPTIONS, DO YOU USE YOUR: ☐PRIMARY INSURANCE ☐SECONDARY INSURANCE ☐OTHER

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Summit Medical Group, PLLC. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Summit Medical Group, PLLC to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Summit Medical Group, PLLC all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Summit Medical Group, PLLC.

DATE *SIGNATURE OF PATIENT/GUARDIAN*

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Summit Medical Group, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable the judgment of the physician and provided by Summit Medical Group.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Summit Medical Group.

I acknowledge that I have received a copy of Summit Medical Group's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.summitmedical.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Summit Medical Group. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

Patient's Signature | Patient's Name (Printed) | DOB

Patient, _____ , is a minor, or is unable to sign above because: _____
(Name Printed)

Person Giving Consent | Relation to Patient

Patient's Name:_____
DOB:_____

SUMMIT MEDICAL GROUP
Health Information Questionnaire
Patient Health History

Today's Date: _____ Primary Care Physician: _____ MRN: _____

Patient's Name: _____ Date of Birth: _____ Sex: _____
Preferred Pharmacy: _____ Pharmacy Telephone Number : _____
What is the reason for your visit today? _____
What Medications are you currently taking? *(Attach list if necessary)*

Medication	Dose	How often taken

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication? _____
Are you: ☐ Right -handed ☐ Left -handed
Marital Status : **U**
Women: Number of Children: _____ Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____
Last Mammogram: _____ Last Bone Density: _____ Last Pap Smear: _____
Are you currently: ☐Pregnant ☐Nursing ☐ N/ A Still having periods? ☐Yes ☐No
Men: Last Prostate Specific Antigen (PSA) Test: _____
Men and Women over 50: Last colonoscopy : _____ Physician/ Location :**/** _____
Do you have a Healthcare Power of Attorney? ☐Yes ☐No **Do you have a Living Will?** ☐Yes ☐No
When were your last Vaccinations? (please list approximate dates)
Flu : _____ Tetanus: _____ Pneumonia: _____ Shingles: _____

MMR: _____ Hepatitis B: _____ Other: _____

Past Medical History: *(Check all that apply and list approximate year of diagnosis)*

☐ Anemia _____	☐ Genital/Urinary Disease _____	☐ Osteoarthritis _____
☐ Anxiety/Depression_____	☐ Gout _____	☐ Osteoporosis _____
☐ Asthma_____	☐ Heart Disease _____	☐ Peripheral Neuropathy _____
☐ Autoimmune Disorder (Type) _____	☐ High Blood Pressure _____	☐ Peripheral Vascular Disease _____
☐ Blood Disease _____	☐ High Cholesterol _____	☐ Psoriasis _____
☐ Bipolar Disorder _____	☐ HIV/Aids _____	☐ Rheumatoid Arthritis _____
☐ Cancer (Type) _____	☐ Liver Disease _____	☐ Seizures _____
☐ COPD/Emphysema _____	☐ Lung Disease _____	☐ Thyroid Disease _____
☐ Diabetes (Type) _____	☐ Lupus _____	☐ Tuberculosis _____
☐ Dementia _____	☐ Kidney Disease _____	☐ Ulcers _____
☐ Eye Diseases (Type) _____	☐ Migraines _____	

Patient Health History

Past Surgeries: *(Please list with approximate dates)*

Family History:

Have any members of your immediate family*(parents, siblings, grandparents)* ever had the following: *(if yes, whom)*

☐ Arthritis _____	☐ liver Disease _____
☐ Asthma _____	☐ Lupus _____
☐ Bleeding Disorders _____	☐ Lung Disease _____
☐ Cancer (What Type) _____	☐ Migraines _____
☐ Diabetes _____	☐ Osteoporosis _____
☐ Heart Disease _____	☐ Psoriasis _____
☐ High Cholesterol _____	☐ Rheumatic Fever _____
☐ High Blood Pressure_____	☐ Stroke _____
☐ Kidney Disease_____	☐ Thyroid Disorders _____

Do you use tobacco products? ☐ Yes ☐ No ☐ Quit What type/Amount per day: _____
How many years have, or did, you used tobacco? _____
Do you drink more than 2 alcoholic beverages per day? ☐ Yes ☐ No
Do you use drugs for reasons that are not medical? If so, please list _____

Please list any specialists you are seeing:

Please list any other relevant information or questions you may have for the physicians today:

Summit Medical Group

Consent for Healthcare Messages

Account # _____ DOB: _____

I _____ give permission to the physicians and their staff at Summit Medical Group to:

Initial chosen options:

TEXT/ VOICE Messages for General Healthcare Information

_____ leave **text and voice** messages at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my healthcare when I am not available.

Cell _____ Phone _____

_____ leave **voice messages** regarding my health information including results and diagnostic information, payments of balance, care plans, referrals, when I am not available at the following number.

Cell _____ Phone _____

Sharing of Your Health Information and Results

_____ I give permission to the physicians and their staff at Summit Medical Group to share my health information including results, diagnoses, and appointment information with the following person(s).

The persons you list will also be permitted to pick up prescriptions on your behalf if you are unable.

Name	Relation	Phone Number

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Rev 10/17

HIPAA Privacy and Release of Information Authorization

Patient Name:
Patient ID:
Patient DOB:

I, _____ hereby authorize _____ and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Summit Medical Group. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Financial Policy, Missed Appointment Agreement and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient/Guardian Printed Name Date

_____

Patient/Guardian Signature

Missed Appointment Agreement

Thank you for trusting your medical care to Summit Medical Group. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's need for office visits in a timely manner. When a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Appointment Cancellation/No Show Policy:

- Effective July 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$40.00 fee.**
- If a **third** No Show or cancellation/reschedule without a 24 hour notice should occur, the patient may be **dismissed** from Summit Medical Group.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit and/or upon receipt of statement**, whichever occurs first.
- As a courtesy, we make reminder calls for appointments. Regardless of whether or not you receive a call reminder, the above Policy will remain in effect.

I have read and understand Summit Medical Group's No Show/Missed Appointment Guidelines and agree to its terms.

Patient Printed Name	Date of Birth	Date
Patient Signature (or Parent/Guardian if minor)	Relationship to Patient	