Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Mailing Address _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Relationship to Patient _____ Date of Birth MM_____ /DD_____ /YYYY_____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Mailing Address _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

CONSENT FOR TREATMENT:

I consent to services, treatment, and diagnostic procedures including, but not limited to, medications, lab tests, and other studies, which may be ordered by my physician, and consultants as selected by my physician at Bossier Family Medicine, LLC. I have the right to ask questions and receive information about any services that I may receive.

INJECTIONS:

I understand if I receive any medications by injection there are risks associated. These risks include pain, scarring, bleeding, infection, and possible dimpling of the skin. By signing, I am stating that I understand these risks and consent for treatment in this manner. I also understand not all insurance carriers pay for injectable medications as treatment. In the event my insurance does not pay for steroids, antibiotics, medications for nausea, or any other medications, I will be billed in full.

FINANCIAL POLICY:

It is our policy to require payment of all charges at the time of service. As a courtesy to you, we file the bill with most insurance carriers as long as you have provided us with all the policy numbers, addresses, your place of employment, and any other pertinent information. By signing this consent, you assign all rights, title, and interest. You authorize direct payment to Bossier Family Medicine, LLC of any insurance benefits or benefits under the Social Security Act for services. You are responsible for all deductibles and charges not covered by insurance at the time of visit or service.

RELEASE OF INFORMATION:

I acknowledge, that to the extent necessary, to determine liability for payment or to obtain reimbursement, Bossier Family Medicine may disclose my records to any person Social Security Administration, insurance or benefit payer, healthcare service or plan, or worker's compensation carrier, which is or may be, liable for all or any of the charges. I also give my permission for both personal and medical information to be released to other treating physicians, healthcare providers, and audit committees for the purpose of quality improvement and applicable state and federal agencies.

_____ _____

Patient / Responsible Party Date

Bossier Family Medicine

PATIENT PORTAL REQUEST FORM

The Patient Portal is a secure online access to a portion of your "chart" in our office. Due to privacy issues once you complete the form we ask that you return the form in person. We will need a copy of your picture ID to verify you are the correct person requesting this information. You must complete a form for each patient you are requesting portal access on.

Patient Name: _____
(if patient is under the age of 18 parent/guardian must be listed and a copy of their picture ID will be obtained)

Patient's Date of Birth: _____

Parent/Guardian: _____

E-mail Address:_____
(please print and use the proper upper/lower case when needed – this is where replies to your request will be sent)

Phone Number: _____
(This is needed in case your email does not go through)

Do you want a custom user name?
(user name is typically first name last name and year of birth, i.e JOHNSMITH1978)

YES NO _____
requested name

By signing and dating this form, I am authorizing Bossier Family Medicine to create a patient portal username and password for the patient listed above. I understand that this information will be emailed to me within 2 business days at the email I have given above.

Signature:_____ **Date: _____**

Missed Appointment & Cancellation Policy

Our office requires advanced notice when canceling your appointment. If you need to re-schedule your appointment, please give at least a one business day notice.

Please read the policy below and sign where indicated:

- If you need to reschedule or cancel an appointment, please give us a one business day notice to avoid a charge.
- If you fail to arrive for your scheduled appointment and have not given us a business day notice, you may be charged a missed appointment fee.
- The charge for a missed appointment or cancellation within one business day of the scheduled appointment is $25.00. This is not covered by insurance plans and is your responsibility to pay.

_____ _____

Patient - Print Name Relationship to Patient

_____ _____

Signature (Parent/Legal Guardian Date