

**TOTAL PRIMARY CARE
Patient Registration Form**

Today's Date: _____

Patient Information:

Last _____ First _____ Middle _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell: _____ Email: _____

Occupation: _____ Marital Status: M _____ S _____ W _____

Employer: _____ Employer phone: _____

Insurance Information:

Name of Subscriber: _____ DOB: _____ Phone#: _____

Name of Insured: _____ Relationship to Subscriber: _____

Primary Ins Carrier: _____ Policy #: _____ Group #: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Emergency Contact:

Name of local friend or relative not living with you: _____

Relationship to patient: _____ Home# _____ Cell# _____

Pharmacy Information:

Name _____

Address _____

City _____ State _____ Zip code _____

Phone # _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Birth: _____ Sex: M _____ F _____ Do you have an Advanced Directive? Y or N

Race (please circle): African American Native American Asian Caucasian Hispanic Pacific Islander Decline to Answer Other

Ethnicity (please circle): Of Hispanic Origin Not of Hispanic Origin Decline to Answer

Previous or referring doctor: _____

PERSONAL HEALTH HISTORY:

Date of *last complete physical exam*: _____

Briefly state the reason for your visit today: _____

List any chronic medical problems that other doctors have diagnosed:

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____
5. _____ Year: _____

List any allergies to medications:

1. _____ Reaction you had: _____
2. _____ Reaction you had: _____
3. _____ Reaction you had: _____

List your prescribed medications and over-the-counter drugs, including vitamins and supplements:

1. _____ Strength: _____ How often: _____
2. _____ Strength: _____ How often: _____
3. _____ Strength: _____ How often: _____
4. _____ Strength: _____ How often: _____

Surgeries and any other hospitalizations:

1. Year: _____ Reason: _____ Hospital: _____
2. Year: _____ Reason: _____ Hospital: _____
3. Year: _____ Reason: _____ Hospital: _____
4. Year: _____ Reason: _____ Hospital: _____

Women Only:

Date of your last menstruation? _____ Post Menopausal? Yes _____ No _____
Number of pregnancies? _____ Number of live births? _____
Are you pregnant or breastfeeding? Yes _____ No _____
Have you had a hysterectomy? Yes _____ No _____
Date of last Mammogram? _____ Date of last Pap? _____

Men Only:

Have you had any kidney, bladder, or prostate infections with the last 12 months? Yes _____ No _____
Do you have any problems emptying your bladder completely? Yes _____ No _____
Do you have any difficulty with erection or ejaculation? Yes _____ No _____
Do you have any testicle pain or swelling? Yes _____ No _____
Date of last prostate or rectal exam? _____

Family Health History:

Please list any significant health problems for the following family members and their age.

Father's Age: _____ 1. _____
2. _____
Mother's Age: _____ 1. _____
2. _____

Health Habits and Personal Safety: *The following questions are confidential.*

Do you drink Alcohol? Yes _____ No _____
If yes, what kind? _____ How many per/wk? _____
Do you use tobacco? Yes _____ No _____
If yes, what kind? _____ How often? _____
Do you currently use recreational or street drugs? Yes _____ No _____
If yes, what kind? _____
Have you ever given yourself street drugs with a needle? Yes _____ No _____
Have you ever been dependent on any substance or had any problems with abuse? Yes _____ No _____

TOTAL PRIMARY CARE OFFICE POLICIES

Thank you for choosing Total Primary Care as your primary care specialist. We are committed to providing the finest personalized and professional care possible for our patients. We hope the following information will help answer some of your questions and help you understand how our office operates.

Office Hours

Monday through Thursday 8:30 am to 4:30 pm/Friday 8:30 am - 3:30 pm
We are closed for lunch from 12 to 1 pm M-Th.

Scheduling Appointments

Appointments can be scheduled by phone, in person at the office, or via on-line request. We ask that you arrive 15 minutes before your scheduled appointment. Patients arriving late for their appointment may be rescheduled and will be subject to a \$75 cancellation fee so please contact the office ahead of time if you cannot make your appointment on time.

Cancellation Policy

We realize patients may need to change their appointments; however, **we require 1 full business day notification** of cancellation for appointments so we may offer that time to another patient. If you fail to cancel, you will be billed the cancellation fee.

After Hours

Under no circumstances will refill requests be processed during non-office hours. All refill requests should be made prior to noon on Fridays or prior to holidays. Prescription refills, appointment scheduling, and lab/test results will be handled only during routine office hours.

Dr. Ahmann does not attempt to make diagnoses during non-business hours. We recommend utilizing your local urgent care facility for minor emergencies during non-office hours. If you have a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Medication Refills

Please allow at least 2 business days to process refills. Please take the “no refills” message on the prescription bottle as a reminder to schedule your next office visit. Please understand that this policy is for your safety and in your best interest. Some medications require laboratory monitoring and some require more frequent visits (such as controlled substances). We care enough to be sure that you are being treated properly for your ongoing medical needs.

Medical Forms

There will be a fee charged for filling out a variety of health related forms. The fee will be \$25.00 for up to 3 pages and \$5.00 per page thereafter. Forms cannot be filled out while you wait. A visit with the Dr. may be required.

Patient Signature: _____

TOTAL PRIMARY CARE FINANCIAL POLICIES

Thank you for choosing TPC. We are committed to providing you with quality and affordable health care. The following is a summary of our financial policies.

FORMS OF PAYMENT: We accept ***most major credit cards*** or ***cash***. We **DO NOT ACCEPT PERSONAL CHECKS.**

INSURANCE: We participate in most insurance plans, including Medicare, but not currently Medicaid. It is your responsibility alone to determine whether we are contracted with your insurance company and your plan. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we are contracted, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your insurance eligibility.

CO-PAYMENTS AND DEDUCTIBLES: All co-pays and/or deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

NON-COVERED SERVICES: *Please be aware that some or maybe all of the services that you receive may not be covered* or considered reasonable or necessary by Medicare or other insurers. *It is the patient's responsibility to pay for these services either at the time of service or upon receipt of an invoice sent to you from TPC.*

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current, valid insurance card or information in order to verify insurance eligibility and benefits. If you do not provide us with current and correct insurance information in a timely manner then you may be responsible for the balance of the claim.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that *the balance of your claim is your responsibility whether or not your insurance company accepts your claim.* Your insurance benefit is a private contract between you and the insurance company and TPC is not a part of that contract.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes. This will help you receive the maximum insurance benefit as well as assist you in getting your claims paid promptly.

NONPAYMENT: If your account is more than 60 days past due, you will receive a letter stating that you have 10 days to pay the full amount. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged as patients from this practice. You will be responsible for any and all legal, collection, and late fees. If this is to occur, you will be notified by mail

that you have 30 days to find alternate medical care. During that 30-day period, Dr. Ahmann will only be able to treat you or your family members on a **cash or credit card only** basis for those services rendered.

MISSED APPOINTMENTS: We require at least **1 full business day** of notice if you are unable to make your scheduled appointment. You will be charged **\$75.00** if we are not notified of the cancellation within that time frame.

TPC is committed to providing the best service for all of our patients. Our prices are representative of the usual and customary charges for our area. Thank you for taking the time to read and understand our payment policy. Please feel free to ask us any questions or to share any concerns you may have.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

Signature of Patient: _____ **Date:** _____

Signature of responsible party: _____ **Date:** _____

TOTAL PRIMARY CARE
NOTICE OF PRIVACY POLICIES (HIPPA)

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Patient Signature

Date

I authorize Total Primary Care to use and disclose my protected health information to the following person (people): _____, _____

Patient Signature

Date