



Complete Family Medicine

A service of Hannibal Regional

New Patient Registration Form

Today's Date: _____

PATIENT INFORMATION

Patient Name -- Last: _____ First: _____ MI: _____
 Previous Last Name (if applicable): _____ Nick Name: _____
 SSN of Patient: _____ Date of Birth: _____
 Birth Sex: (M/F) _____ Current Gender: _____ Gender Identity: _____ Preferred Pronoun: _____
 Address: _____ City, State: _____ Zip Code: _____
 Phone #: _____ Email: _____
 Race: _____ Ethnicity: _____ Language: _____

In case of emergency, name a friend or relative not living with you: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Relationship: _____ Phone: _____
 Who is your primary care physician? : _____

RESPONSIBLE PARTY

Name (Last, First, M.I.): _____ Phone: _____ Cell: _____
 Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip Code: _____ Sex (M/F): _____
 SSN#: _____ Relationship to Patient: _____

Do you have health insurance? Yes No

Are you the carrier of the insurance? Yes No if no, please complete insured's information.

INSURED'S INFORMATION

Name (Last, First, M.I.): _____ Phone: _____ Cell: _____
 Date of Birth: _____ Relationship to Patient: _____
 Name of Insurance: _____ Policy #: _____ Group #: _____

Do you have secondary/supplemental health insurance? Yes No

Are you the carrier of the insurance? Yes No if no, please complete insured's information or (same as above).

Name (Last, First, M.I.): _____ Phone: _____ Cell: _____
 Date of Birth: _____ Relationship to Patient: _____
 Name of Insurance: _____ Policy #: _____ Group #: _____

By signing below, I certify that all information submitted is correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Witness (CFM Representative): _____ Date: _____



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Office Use Only:
EPM _____

Authorization to Release Medical Information

For purpose of reimbursement, Complete Family Medicine is hereby authorized and directed to disclose all or any part of the medical record to my employer, my insurance companies, the Health Care Financing Administration and its agents, Medicaid, or any other agencies as may be necessary to verify or process any and all claims for insurance coverage for third party reimbursement. This Clinic may also release information as may be necessary for continuation of care.

Insurance Assignment and Consent to Treatment

The undersigned hereby assigns all monies payable or to be paid by any insurance company(ies), individual(s), corporation(s), or from any source whatsoever for services rendered to the below patient of Complete Family Medicine a service of HRHS. I hereby request and consent to receive treatment from this Hannibal Regional Health System Service. I understand that this clinic is staffed by a healthcare team, which may include a physician(s), nurse practitioner(s), nurses and technicians. I freely accept care from this healthcare team and acknowledge the establishment of the provider-patient relationship. I further understand that this healthcare team will provide information and/or care including but not limited to, medical history, physical examination, assessments of health status, laboratory and diagnostic testing, emergency procedures, suturing, prescription medications, and immunizations; however, I maintain the right to make all decisions regarding my care. This consent is to remain in effect until I revoke it in writing. I understand that I have the right to revoke this consent at any time.

Agreement to Pay

In consideration of services provided, each of the undersigned (including the person signing as a representative for the patient is the patient, is his/her spouse, unemancipated child or other lawful dependent) agrees to pay all charges of Complete Family Medicine and independent contractors. Each bill is due and payable upon presentation or mailing of the same to either the patient or any of the undersigned. If any bill becomes delinquent, the undersigned agrees to pay all collection agency fees, all attorney's fees and all other collection expenses incurred by Complete Family Medicine and/or the independent contractors. If suit is filed to enforce collection, it may be filed in the county where the agreement is being signed and entered into.

Initial Here: _____ I acknowledge that I have read the Financial Policy that is posted and understand my financial obligations regarding my visit(s) to Complete Family Medicine. A copy of the policy is available upon request.

HIPAA DISCLOSURE

I give CFM permission to share or discuss my health information (including your condition, plan of care, labs, x-rays, appointments etc.) with the following family, friends or others who will be involved in my care or payment for care. If releasing information to anyone, including those listed below, for purposes other than for care or payment, I understand I will be required to sign a separate Medical release form.

Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____

By signing below, I acknowledge that I have received a copy of Complete Family Medicine's Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure. The Notices describe how my health information may be used or disclosed and my rights and responsibilities as a patient of CFM/HRHS. I understand that I should read them carefully. I am aware that the Notices may be changed at any time and that I may obtain a revised copy of the Notices by contacting CFM/HRHS. I

CERTIFY THAT I UNDERSTAND AND AGREE TO THE PROVISIONS CONTAINED WITHIN THIS AGREEMENT

PRINT Patient's Name: _____ **Date of Birth:** _____

PATIENT/GUARDIAN SIGNATURE: _____ **Today's Date:** _____

Witness (CFM Representative): _____ **Today's Date:** _____

If you are signing for the patient, please complete the following information:

Name: _____ **Date of Birth:** _____

Relationship to the Patient: _____ **Phone:** _____