Restoration
OSTEOPATHIC MEDICINE

Patient Registration

Name:		**( ) Female ( ) Male**	**Date of Birth:**
Address:			
City:	**State:**		**Zip:**
Cell Number:		**Home Number:**	
Email:			
Preferred Pharmacy:			**Pharmacy Address:**
Race: ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown ☐ Decline to Answer	**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer		**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Decline to Answer
Emergency Contact:			
Relationship to Patient:	**Contact Number:**		
How did you hear about us?			

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I authorize Restoration Osteopathic Medicine to release any information required to process my claims.

Patient/Guardian Signature_____ **Date** _____

Consents, Releases, and Agreements

Patient Name (please print) _____

Date of Birth_____

Notice of Uses and Disclosures of Protected Health Information:

I acknowledge that I have been provided with Restoration Osteopathic Medicine's (ROM) Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of ROM, as well as my individual rights and the duties of ROM with respect to my protected health information. I understand that Restoration Osteopathic Medicine may use or disclose my protected health information (PHI) to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. PHI includes information created, maintained, or received by ROM that identifies me, or from which my identity could be determined, and which relates to my past, present or future physical or mental health, condition, treatment, or payments for medical services. ROM reserves the right to change the privacy practices that are described in its Notice of Privacy Practices. ROM will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting ROM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Office Policies (Please see posted policies; a copy can be made for your records):

- No Show and Cancellation Policy
- No Smoking Policy
- HIPAA Compliance

Patient Signature_____ **Date _____**

Financial Agreement and Assignment of Benefits:

Medicare: I request that payment under the medical insurance program be made either to me or to Restoration Osteopathic Medicine (ROM) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.

All other Payors: I authorize payment directly to ROM of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to ROM in an amount not to exceed the charges for services rendered. I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered. If I am unable to pay in full, I understand that a payment plan may be established.

Patient Signature_____ **Date _____**

Release of Medical Information

Restoration
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Patient Name:_____ **Date of Birth:** _____

Restoration Osteopathic Medicine limits the release of protected health information (PHI) to that permissible by patient confidentiality laws. According to HIPAA guidelines, permitted reasons for release of PHI include treatment, payment, scheduling and healthcare operations, or as otherwise allowed by the **explicit signed authorization** of the patient or authorized representative.

Permission to Leave a Detailed Message:
I hereby permit medical providers and staff of Restoration Osteopathic Medicine to leave a detailed message at the following phone **number:**_____ and/or e-mail **address:** _____

☐ **I Decline. Please do not leave me detailed messages.**

Permission to Verbally Discuss PHI with Family Members/Caregivers:

I hereby authorize medical providers and personnel of Restoration Osteopathic Medicine to discuss my protected health information with the following person(s):

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

☐ **I Decline. Please do not discuss my care with anyone other than as permitted by HIPAA regulations.**

The following information cannot be released without authorization as required by state or federal law. **By initialing the lines below, you authorize the release of the following protected or sensitive material:**

_____ Information regarding the diagnosis and treatment for HIV/AIDS

_____ Psychotherapy notes regarding mental health

_____ Treatment for alcohol or drug abuse

- This authorization will expire 730 days (2 years) from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- This form is not valid unless signed and dated.

_____ _____

Signature of Patient/Personal Representative **Date**