Family Health Care LLC
72 N Plaza Blvd.
Chillicothe, Ohio 45601
(740) 851-4400
(740) 851-4403

NEW PATIENT REGISTRATION FORM:

PATIENT INFORMATION:

Patient's Legal Name: Last_____First_____Middle_____
Patient's Preferred Name (if differs from above): _____
Patient Maiden Name/Previous Name Used: _____
Date of Birth: ___ /___ /_____ Sex: _____ Gender: _____ Pronouns: _____
Patient's Address: _____City_____St____Zip_____

PARENT/GUARDIAN INFORMATION:

Guardian #1 Name: _____ Guardian #2 Name: _____
Phone #: _____ Phone #: _____
Address (if different)_____

PRIMARY INSURANCE:

Insurance Co. Name: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Policy #: _____
Policy Holder Social Security#: _____Group #: _____
If GUARANTOR address differs from the above provided address, please list here: _____
_____

SECONDARY INSURANCE:

Insurance Co. Name: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Policy #: _____
Policy Holder Social Security#: _____Group #: _____

POLICY ACKNOWLEDGEMENT AND AGREEMENT:

I certify that the above information is correct, and hereby authorize payment directly to Williamson and Associates, Family Health Care. Although every attempt will be made to bill insurance directly, I understand that I am financially responsible to Family Health Care for any co-payments, co-insurance or charges not covered by insurance or for charges incurred by failure to obtain insurance authorization. I acknowledge that I have read and agree to adhere to all office policies including release of information, consent for care, insurance information, missed appointments and payments. **Please be aware that we will vault your credit card and bill the card directly after your appointment for the remaining balance not covered by insurance. See "Vault Policy" for further information.**

_____ _____
Signature of Insured Person or Authorized Rep. Date

_____
Printed Name of Insured Person or Authorized Rep

AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY PRACTICES

I authorize the release of information from the above-named patient's medical record that may be necessary to make reimbursement for any of all the services rendered. I further understand that Family Health Care cannot be held responsible for the subsequent passage of information that might occur by the third parties themselves. I acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

MISSED APPOINTMENTS

I understand that I am responsible for being on time for my appointments. **Failure to cancel an appointment 24 hours before the date will result in being billed a $50.00 "missed appointment fee".** If I am more than 10 minutes late for an appointment, it will be regarded as a missed appointment. ***Three missed appointments without proper notice will be dismissed.***

CONSENT FOR CARE

On behalf of the above-named patient, I do hereby apply for and voluntarily consent to outpatient care.

INSURANCE INFORMATION

Please note: Please present your insurance card(s) at the time of the appointment and be prepared to pay any necessary co-payment. Co-payments are due at the time of service (cash, check, Visa, MasterCard, Discover accepted).

PAYMENT INFORMATION

Family Health Care has partnered with AthenaOne Medical to securely store patients' debit/credit card information. AthenaOne Medical provides encrypted and secure storage of patient credit/debit card information in strict accordance with the Payment Card Industry Data Security Standards (PCI DSS). These are global standards for transmission and storage of financial data. For more information, please go to https://www.pcisecuritystandards.org. If you have an outstanding balance, we will make arrangements with you at your visit to collect the balance, either in full or via a payment plan with automatic monthly billing to your credit card. If you have a co-payment due at the time of service, this amount will also be collected. In addition, if we have your deductible information, we may request to charge your credit card for the balance due from the visit. We will reconcile this amount once your insurance carrier has processed our claim for services provided.

Medical Records & Forms Fee

**TURN AROUND TIME FOR ALL FORMS is 5-30 DAYS **
** Standard Daycare form - No Charge **
School or Camp form: Forms to be filled out by parent or guardian and then signed by Provider-No Charge.
** Family and Medical Leave (WH-380) and other non-standard forms - $25.00*
Copy of Medical Records to be faxed; mailed, or picked up see below:
Complete copy of medical records $25.00 first 20 pages, pages 21-25 are $0.50 per page.
These fees are paid prior to release of records/forms.

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AUTHORIZATION TO LEAVE LAB RESULTS

I _____, parent/representative of _____,

D.O.B. __/__/____, give *Family Health Care* the authorization to leave any lab results on the following voicemails:

Home: _____ Cell: _____

Signature: _____ Date: _____

E-PRESCRIBING SYSTEM

Please provide your preferred pharmacy below:

Local Pharmacy
Name: _____
Address: _____
Phone: _____

Mail Order Pharmacy (If Applicable)
Name: _____
Address: _____

RELEASE OF HEALTH INFORMATION PATIENT OVER 18 YEARS OLD

I _____, D.O.B. ___/___/_____, am 18 years or older. I give permission to *Family Health Care* to release my health information to the following people at the following numbers:

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Patient Signature: _____ Date: _____