MD First
Primary & Urgent Care

PATIENT REGISTRATION [*Please fill this section out completely*]

Name (last, first, middle initial)		DOB	Sex	Social Security #
Address	City		State	Zip Code
Email Address		Primary Phone #		Secondary Phone #
Marital Status	Employer Name & Phone #			

DEMOGRAPHICS

Preferred Language	Ethnicity	
☐ English ☐ Other:_____	☐ Hispanic or Latino	☐ Non-Hispanic
Race		
☐ African / African American	☐ Asian / Asian American	☐ Caucasian / European American
☐ Native America / Alaskan	☐ Native Hawaiian / Pacific Islander	☐ Other

PRIMARY CARDHOLDER'S INFORMATION [If different from information above]

Insured's Name			Insured's DOB
Insured's Phone #	Driver Lic #		Insured's Social Security #
Insured's Address (if different than above)	City	State	Zip Code

INSURANCE INFORMATION

Medical Insurance	Subscriber Name		Relation to Subscriber
Group / Member #	Insurance Deductible		Medicare #
Address (if different than above)	City	State	Zip Code
Secondary Medical Insurance	Subscriber name		Relation to subscriber
Group / Member #	Insurance Deductible		
Address (if different than above)	City	State	Zip Code

PRIMARY CARE PHYSICIAN

Name/ Practice name	Phone	Fax
Would you like to learn more about making Amrendra Kumar MD your primary care physician Y / N		

EMERGENCY CONTACT

Name	Relationship	Phone#	Other Phone #

DISCLOSURE OF HEALTH INFORMNATION (Who we may disclose all your health related information)

Name	Relationship	Phone
1		
2.		

I understand that it is my responsibility to know the terms and conditions of my coverage and to provide a copy of the most recent insurance card.

Signature:_____ Relationship to Pt:_____ Date:_____

Sign & Date

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HIPAA Information and Treatment Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov. If you would like to receive a copy of our HIPAA, please ask our front desk to provide you one.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient records are stored in the offsite servers of ADP Advanced MD. During the normal course of providing care some patient records may be left, temporarily, in administrative areas such as the front office, physician work station, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
5. Your confidential information will not be shared for the purposes of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Consent for Medical Treatment & Financial Obligation

Thank you for choosing MDFirst Primary & Urgent Care as your healthcare Provider. We are committed to providing quality medical care. We ask that you read, sign and return this form to us prior to your treatment. Payment is required at the time of service and may be in the form of cash, debit, or credit card. **We do not accept personal checks.** If you choose to bill your insurance, we cannot retroactively charge you a cash price after you've received your bill from insurance

Patient or Patient's legal representative agrees to the following terms of treatment:

I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding my illness, injury or other health concern affecting me at any time I present at MDFirst Primary & Urgent Care. These services may include, but not limited to laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures. My personal information will be updated at the time of each visit to MDFirst Primary & Urgent Care. I am a patient, the parent of a minor child, or the legally authorized representative of the patient and I authorize MDFirst Primary & Urgent Care to submit an insurance claim on my behalf. I understand that I am financially responsible for any non-covered service. I have read and understand this treatment agreement.

Patient or Patient's legal representative agrees to the following financial terms:

I, the patient or authorized representative, understand that payment is my responsibility regardless of insurance coverage. If a service is provided that is not covered by my Insurance, or if my Insurance has lapsed, I will be responsible for the charges in full. I understand that if my Insurance has not paid after 5 days from the billing date that I will be billed directly. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service/ COLLECTION AGENCY. If my account is sent to an outside billing service/ COLLECTION AGENCY there will be a 20% finance charge.
I hereby authorize MDFPUC to furnish patient's Insurance company all information (including HIV, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested concerning illness or injury. I also authorize the release of information regarding work related injuries to my employer.
I have read and agree to MDFirst Primary & Urgent Care (MDFPUC) payment policy.

Print Patient Name

I, _____
do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Notice of Privacy Practices and in this form, for medical treatment, financial obligations, and patient and practice obligations. I understand that this consent shall remain in force from this time forward. I have reviewed a copy of MDFirst Primary & Urgent Care's Privacy Notice.

Signature:_____Relationship to Patient: _____ Date: _____

Sign & Date

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Medical History Form

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

REASON FOR VISIT

ALLERGIES

1.	4.
2.	5.
3.	6.

CURRENT MEDICATIONS WITH DOSAGE: (Please include Over the counter medications)

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

PERSONAL / FAMILY MEDICAL HISTORY: (Please specify Personal or Family)

Heart Disease	Asthma	Seizures
High Cholesterol	Sinus problems	Stroke
High Blood Pressure	Seasonal allergies	Headache/ migraine
Anemia	Ear problems	Anxiety/ depression
Swollen ankles	Kidney stones	Bipolar
Diabetes	Cancer	Ulcerative colitis/ Crohn's
Arthritis	Enlarged prostate	Rheumatoid arthritis
Thyroid problem	STD	Other
Hernia	Uterine fibroid	Other
HIV/ AIDS	Menstrual problems	Other
COPD	Glaucoma	Other

SOCIAL HISTORY:

Cigarettes		Packs/day	**Alcohol**		Drinks/week	**Drug Abuse**	
Marital Status:							

SURGICAL HISTORY:

1.	3.	5.
2.	4.	6.

FEMALE HISTORY:

Are you Pregnant? Y / N	Date of Last Menstrual Period:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

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- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost- based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Amrendra Kumar, MD
Phone: 803-283-2300
E-mail: mdfpuc@mdfirsthealthcare.com

8. Effective Date. This Notice is effective November 1st, 2013.