Beckett Ridge Family Medicine **Patient Registration Form**

PATIENT INFORMATION:

Last Name: _____ First Name_____ M.I._____

Maiden Name _____ Date of Birth: _____ SSN_____ Age _____

Address: _____ Apt #____ City_____ State____ ZIP_____

Primary Phone: _____ Secondary Phone: _____ Marital Status: _____

Employed: Y / N Employer: _____ Work Phone: _____

Employer Address: _____ Occupation: _____

Email Address: _____ Pharmacy (Name and Phone):_____

INSURANCE INFORMATION

Primary Insurance: _____ Insured Relation to Patient_____

Insured Last Name: _____ First Name: _____ M.I._____

Date of Birth: _____ SSN_____ Age _____

Member/Subscriber ID: _____ Group Number:_____ CoPay: _____

Secondary Insurance:_____ Insured Relation to Patient _____

Insured Last Name: _____ First Name: _____ M.I._____

Date of Birth: _____ SSN_____ Age _____

Member/Subscriber ID: _____ Group Number: _____ CoPay: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation to Patient_____

Primary Phone: _____ Secondary Phone:_____

Insurance/Medical Disclosure:

I authorize Beckett Ridge Family Medicine to render treatment and/or medical care for the betterment and well being of myself and/or my dependent. I authorize the release of my independently identifiable health information (including a photocopy of my signature) for the purposes of providing care and processing insurance claims. I authorize payments of benefits due to me to be made directly to the practice or physician(s) within this practice. In the event I receive payment from my insurance company, carrier or agent, I acknowledge that the funds belong to the practice, or the physician(s) of this medical practice. I understand that I am financially responsible for all charges including those not covered by my insurance company. I give my permission to leave messages regarding confirmation, changes, or cancellation of my office appointments, or financial information on my voicemail, with a family member, or any other adult person answering my telephone. I further, give permission for this office to release any medical information dictation, lab results, or billing information about me to any medical specialist, physician, healthcare giver or agency, or any other person(s) I authorize.

Patient/Parent Signature: _____ Date: _____

Beckett Ridge Family Medicine

Patient Name: **DOB:** **Today Date:**

Today, I have the following symptoms .....

General/Constitutional
- ☐ Fatigue
- ☐ Headache
- ☐ Lightheadedness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sleep disturbance
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain

ENT
- ☐ Ear pain
- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Decreased hearing
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Sinus pain
- ☐ Nosebleeds
- ☐ Changes smell
- ☐ Decreased sense of smell
- ☐ Bleeding gums
- ☐ Change in taste
- ☐ Dentures

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Irregular menses

Hematology
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Hx anemia
- ☐ Hx transfusion

Breast
- ☐ Breast lump
- ☐ Breast pain
- ☐ Breast swelling
- ☐ Gland swelling
- ☐ Nipple discharge
- ☐ Red skin

Respiratory
- ☐ Cough
- ☐ Sputum production
- ☐ Coughing up blood
- ☐ SOB at rest
- ☐ SOB with exertion
- ☐ Wheezing
- ☐ Chest pain
- ☐ Pain with inspiration

Cardiovascular
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Palpitations
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Dyspnea on exertion
- ☐ Difficulty lying flat
- ☐ Leg edema
- ☐ Leg pain with exertion
- ☐ Cyanosis

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Weight loss
- ☐ Decreased appetite
- ☐ Rectal bleeding
- ☐ Blood in stool
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Change in bowel habits
- ☐ Food intolerance
- ☐ Exposure to hepatitis
- ☐ Jaundice

Women Only
- ☐ Irregular menses
- ☐ Decreased libido
- ☐ Missed periods
- ☐ Heavy menstrual bleeding
- ☐ Painful menses
- ☐ Hot flashes
- ☐ Vaginal discharge/itching
- ☐ Painful intercourse

Genitourinary
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Blood and urine
- ☐ Decreased urine
- ☐ Difficulty urinating
- ☐ Dribbling after urination
- ☐ Incontinence
- ☐ Pain in lower back
- ☐ Hx UTI's
- ☐ Hx kidney stones
- ☐ Hx STD
- ☐ Hernia

Men Only
- ☐ Erectile dysfunction
- ☐ Decreased libido
- ☐ Low testosterone
- ☐ Lump in groin
- ☐ Penile discharge
- ☐ Rash or blisters on penis
- ☐ Scrotal pain
- ☐ Hard testicle
- ☐ Undescended testicle

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Swollen joints
- ☐ Muscle aches
- ☐ Weakness
- ☐ Sciatica
- ☐ Hx Arthritis
- ☐ Hx Gout

Skin
- ☐ Acne
- ☐ Dry skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Blistering or skin
- ☐ Rash
- ☐ Drainage
- ☐ Discoloration
- ☐ Mole(s)
- ☐ Nodule(s)
- ☐ Keloid formation
- ☐ Photosensitivity
- ☐ Skin cancer

Neurology
- ☐ Headache
- ☐ Dizziness
- ☐ Tingling/Numbness
- ☐ Memory loss
- ☐ Fainting
- ☐ Coordination problems
- ☐ Difficulty speaking
- ☐ Gait abnormality
- ☐ Loss of strength
- ☐ Loss of use of extremity
- ☐ Balance difficulty
- ☐ Paralysis
- ☐ Seizures
- ☐ Tics
- ☐ Tremor
- ☐ Transient loss of vision

Psychiatric
- ☐ Depressed mood
- ☐ Anxiety
- ☐ Irritability
- ☐ Stressors
- ☐ Sleep disturbance
- ☐ Suicidal thoughts
- ☐ Marital problems
- ☐ Mood disorder
- ☐ Hallucinations Aud/Visual
- ☐ Delusions
- ☐ Eating disorder
- ☐ Mental or physical abuse
- ☐ Substance abuse

Cancer Self-Management
- ☐ Smoking cessation
- ☐ Colonoscopy
- ☐ Skin exam
- ☐ Use of sunscreen
- ☐ Breast self-exam
- ☐ Mammogram
- ☐ Pap testing
- ☐ PSA testing

☐ No Symptoms Today

Help us update your medical history, check the appropriate box of the symptoms listed above that apply to you now or in the recent past.

Medical History Form
Beckett Ridge Family Medicine

Patient Name: _____
DOB: _____

Medication (Include any Vitamins or OTC products)	**Dose (MG)**	**Directions for use**

Medical Problems (example: High Blood Pressure, High Cholesterol, History of Kidney Stones)

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies (example: None, Peanuts, Penicillin)

_____
_____
_____

Surgeries with dates (example: gallbladder removal, tonsil removal, stent placement)

_____
_____
_____

Hospitalizations with dates (anytime you have spent the night in the hospital, not including ER visits)

_____
_____
_____

Family History	**Circle One**	**Medical Problems** (cancers, heart conditions)
Father	Living / Deceased	_____
Mother	Living / Deceased	_____
Father's Father	Living / Deceased	_____
Father's Mother	Living / Deceased	_____
Mother's Father	Living / Deceased	_____
Mother's Mother	Living / Deceased	_____
Sibling's		_____
		_____
		_____
		_____
		_____

Social History:

Tobacco Use	Yes / No	Amount: _____
Drugs (marijuana, cocaine)	Yes /No	Type(s): _____
		Amount: _____
Alcohol	Yes / No	Amount: _____
Marital Status	Single / Married	
Exercise	Yes /No	Amount: _____
Caffeine	Yes /No	Amount: _____

Beckett Ridge
FAMILY MEDICINE

Financial Policies

Patient Name (print): _____ **Date of Birth**: _____

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.
Please read each section carefully and sign at the bottom.

Appointments:

- We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we would appreciate a 24-hour notice. There is a charge of $30 for missed appointments (no show) that are not cancelled within 2 hours of the scheduled appointment time. PLEASE NOTE: Multiple no shows may result in dismissal from the practice.
- If you are late for your appointment, we will do our best to accommodate you. However, if it is more than 20 minutes it may be necessary to reschedule.

Insurance Plans:
Please understand: It is **your** responsibility to keep our office updated with your correct insurance information and to notify us of any insurance changes prior to your scheduled appointment. ***Bring your insurance card to every office visit.***

- If the insurance company you designate is incorrect or the policy is inactive, we will do our best to work with you to get the correct information. However, we **cannot** see you without valid insurance information. You may reschedule your appointment or self-pay for the visit.
- It is **your** responsibility to understand your insurance benefit plan. Only you and your member services can verify if our office or our laboratory (LabCorp) are in your plan network. We can't determine if services are covered prior to being seen, and we are not able to estimate what your charges will be prior to processing with your insurance company.

Co-pays and/or account balances are due at each visit:

- Co-pays **cannot** be billed. If you are unable to pay co-pay at the time of your visit it may be necessary to reschedule.
- If you have a balance on your account, regardless of whether you have received a statement, you will be asked to pay that balance prior to being seen. We make every effort to notify you prior to your appointment of any balances. If you need to set up payment arrangements please contact our billing department *prior* to coming in for your appointment.

Referrals:

- It is **your** responsibility to know if a written referral or authorization is required to see specialists, whether pre-authorization is required prior to a procedure, and what services are covered.
- Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, we must approve referrals before they are issued.

Financial Responsibility:

- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
- Self-pay patients are expected to pay for services ***in full*** at the time of the visit. Self-pay visits are $75, any testing performed is NOT included and must also be paid in full at the time of the visit.
- We ***do not*** bill medical insurance for auto accident related claims. The cost of each appointment related to an auto accident must be paid ***in full*** at the time of the visit. The charge for such a visit is $75, payable by cash or credit only.
- We do not provide Work-Related Injury/Care Management ("Workers-Comp") services.
- A fee of $25 will be charged for the completion of FMLA, Disability, and other miscellaneous medical statements.
- Patient balances are due immediately upon receipt of your insurance plan's explanation of benefits (EOB). If a statement is issued, balances are due within 21 business days from the statement date. Unless previous arrangements have been made with our billing office, any account balance outstanding longer than 21 days will be charged a $25 late fee for each 21-day billing cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

My signature below acknowledges that I have been made aware of the above policies.

Signature (patient or legal representative**): _____ **Today's Date:** _____
** Name/Relationship to Patient (if signed by legal representative): _____

4870 Wunnenberg Way, West Chester, OH 45069
Phone: 513.860.4600 Fax: 513.860.9059

Beckett Ridge
FAMILY MEDICINE

HIPAA

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alterative means such as sending correspondence to the individual office instead of the individual's home.

Patient's Name (print): _____ **Date of Birth:** _____

I consent to all applicable means of communication by Beckett Ridge Family Medicine (BRFM) unless specified otherwise.

Check **ONLY** the ways in which you **do NOT** wish to be contacted:

☐ Telephone:
- Specify restriction(s) [i.e. do not leave message with test results]: _____

☐ Written communication [not applicable for billing statements]:
- Specify restriction(s): _____

☐ Electronic Communication [i.e. patient portal, automated reminder calls/texts, etc.]:
- Specify restriction(s): _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Health care entities must keep record of PHI disclosures, Information provide below, if completed properly will constitute and adequate record.

NOTE: Uses and disclosures for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.

Beckett Ridge Family Medicine has permission to discuss/disclose my health information to the following individuals:
(** If leaving blank, please initial in the box below.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

** _____ **Initial here if your health information should not be disclosed to anyone but you.**

My signature acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 9/24/2013)

Signature (patient or legal representative*): _____ **Date:** _____

*Name/Relationship to Patient (if signed by legal representative): _____

OFFICE USE: BRFM staff member to complete the following if the patient or legal representative refuses to complete this notice of privacy form:

Name of person providing the notice: _____ Date: _____

4870 Wunnenberg Way, West Chester, OH 45069
Phone: 513.860.4600 Fax: 513.860.9059

Beckett Ridge
FAMILY MEDICINE

Authorization for Release of Medical Information

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Last 4 Digits of Soc. Sec. # (optional): _____ Maiden Name (if applicable): _____

Records from:	**Records to:**
Address:	Address:
Phone/Fax:	Phone/Fax::

➢ Information to be released at the request of the individual for continuation of medical care (choose one):

☐ All medical records *

* Only the most recent two (2) years initially, additional dates can be requested when/if necessary.

☐ Only medical records related to a specific treatment and/or date(s) of service:

List treatment and/or applicable date(s): _____

Note: When sending information to our office, *records containing more than 20 pages should be mailed, not faxed.*

The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that except to the extent that action has already been taken based on my authorization, this authorization can be revoked at any time through written notification to the parties involved. I understand that the information disclosed pursuant to the authorization could be redisclosed by the recipient and may no longer be protected by Federal law. I understand that this authorization is voluntary; refusal to sign will not impact my ability to receive treatment.

I understand that, if applicable, the information to be disclosed may include details pertaining to testing/diagnosing/treating drug and/or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), and/or testing for antibodies to the AIDS virus (HIV).

This authorization will expire six (6) months from the date of signature unless specified otherwise here: _____

Signature (patient or legal representative**): _____ **Date**: _____

** Name/Relationship to Patient (if signed by legal representative): _____

4870 Wunnenberg Way, West Chester, OH 45069
Phone: 513.860.4600 Fax: 513.860.9059