

Patient Registration

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Home _____ Social Security #: _____
_____ Cell _____ Marital Status: M S W D Sep. Partner: M ___ F ___
_____ Work _____ Gender _____ Ethnicity _____
_____ Email _____ Race _____ Preferred Language _____

If Patient is under age 18yrs:

Name of Parent / Guardian: _____

Address of Parent / Guardian: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance: _____

Member ID#: _____ Group #: _____ Insured SS #: _____

Name of Insured: _____ Relationship: _____ Insured DOB: _____

Secondary Insurance: _____

Member ID#: _____ Group #: _____ Insured SS #: _____

Name of Insured: _____ Relationship: _____ Insured DOB: _____

Emergency Contact Information:

Contact Name: _____ Phone: _____ Relationship: _____

Pharmacy Information:

Pharmacy Name: _____ Phone: _____

How were you referred to Full Circle? _____

I hereby authorize Full Circle Women's Health/Full Circle Family Care to release any medical information necessary to process any insurance claims and to apply for benefits on my behalf for covered services furnished to me by Full Circle Women's Health/Full Circle Family Care. I certify that the insurance information supplied is correct and up to date and understand I will be responsible for any services not covered by insurance. I also understand that any co-payment or co-insurance is due at time of service.

Patient Signature: _____ Date: _____

Access your Personal Health Record (PHR)!!!

SHORT VERSION: Give us your e-mail address and signature below and we will give you a pin number. You will receive an e-mail with instructions on how to access your records using this pin number.

LONG VERSION: Full Circle Women's Health and Full Circle Family Care are participating in a national effort to expand the use of electronic medical records. Full Circle Women's Health now offers you access to your PHR online. Take ownership of your own health-care by signing up today. When you access your PHR, you will be able to view your appointments, diagnoses, medications, and immunizations.

Why should you sign up to view your PHR? For one reason, it will make your life easier. You have an appointment tomorrow, you can't remember what time it's at and it's too late to call the office. Go online, access your PHR, and instantly see the time of your appointment! You're on vacation and you've gotten that pesky vaginal infection again. What medication was it that you took last time that really helped? By logging into your PHR, you can see exactly which medication you took. You are away at school and you think, "Oh no, am I due for my next HPV shot?" Access your PHR to find out exactly when you had your last HPV shot. There are countless ways to utilize your PHR...

To access your PHR, simply provide us with your e-mail address and sign below. Upon signing, we will give you a print-out with your pin number on it and you will receive an e-mail with simple instructions for logging in to view your PHR. Get started today!

Email: _____

Signature: _____

HIPPA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been given by you, your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

May we leave messages on your voice mail? yes ___ no ___

Name and relationship of anyone authorized to have access to confidential medical records (eg. spouse, parent, primary doctor).

Patient Name: _____ Date: _____

Signature: _____