Patient Registration

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ **Sex:** ❑ Male ❑ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status:** ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ **Sex:** ❑ Male ❑ Female

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ❑ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary insurance: _____ **Patient relation to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer size:** ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ❑ Yes or ❑ No

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date:**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Zam Zam Family Clinic

HIPAA ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The following information on this form is used to facilitate our communication process with you as we strive to provide you with specifies your rights about this authorization under the Health Insurance Portability and Accountability amended from time to time ('HIPAA')

Patient information (Please print clearly):

_____ _____ _____

(First Name) (Last Name) (Date of Birth)

_____ _____

Email (important for patient portal) Phone Number

If we can't reach you at the telephone number listed above, Zam Zam Family Clinic may contact you, including leaving messages.

I authorize Zam Zam Family Clinic to disclose protected Health Information to the following persons:

1. _____ _____ _____

(Name) (Relationship) (Phone Number)

2. _____ _____ _____

(Name) (Relationship) (Phone Number)

Information to be disclosed (CIRCLE ALL THAT APPLY)

1.All medical info. 2. Lab results. 3. All billing and account information.

I understand that Protected Health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and in person. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand Zam Zam Family Clinic cannot require me to sign this authorization. If you refuse to sign this authorization and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice. You have a right to an accounting of the disclosures of your protected health information by the provider or its business associates. The maximum disclosure accounting for disclosures: (a) for treatment, payment, or health care operations, (b) to you or your personal representative, (c) for notification of or to persons involved in an individuals health care or payment for health care, for disaster relief or for facility directories, (d) pursuant to an authorization, (e) of a limited data set, (f) for national security or intelligence purposes, (g) to correctional institutions or law enforcement officials for certain purposes regarding lawful custody. (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

_____ _____

(Patient signature) (Date)

Zam Zam Family Clinic

Office Policies

Phone Calls

Every phone call is important to us and we will attempt to answer/return calls in a timely manner. However, being that we are seeing patients throughout the day we ask that you give us 24-48 hours to return nurse calls and medication refill requests. If you call with an urgent matter we will make every effort to respond immediately.

Appointments

- When scheduling appointments please advise the receptionist of the reason you are being seen.
- Please arrive 10 to 15 minutes before your scheduled appointment so we can review, update, or complete your demographic information. Also please notify us of any changes in your name, address, phone number or insurance.
- Copays, deductibles and private pay payments are due at time of service.
- Please bring your medications bottle or a complete list of your medications with you to each appointment.
- Please be on time for your appointments. If you arrive late you may be asked to reschedule your appointment or give the option to wait until scheduled patients have been seen.
- If you need to cancel or reschedule your appointment we ask that you give a **24 hour notice** to avoid a no show fee.

_____ I understand if I have 3 or more no show appointments within a year I may be dismissed from the clinic. **(Initial)**

Payment Responsibility

_____ I understand that services rendered at time of visit will be billed to my insurance. However, any claims that are partially paid or denied by my insurance provider will thereafter become my responsibility. **(Initial)**

_____ I understand it is my responsibility to pay any co-pays, deductibles, co-insurance, non-covered services or any other balance not paid for by my insurance or third party payor within a reasonable time period, not to exceed 60 days. **(Initial)**

We at Zam Zam Family Clinic understand that some balances may not be paid in full at time of service and we will be happy to assist you in making payment arrangements.

Fees

If an appointment is not cancelled within 24 hours or you do not show for an appointment you will be charged a $25 fee. If you need to obtain medical records outside of myChart you will be charged a $25 fee.

By signing this document I am acknowledging receipt of office policies and financial responsibility. This will remain in effect until revoked in writing

Date: _____ Signed: _____

Name: _____

Zam Zam Family Clinic
965 Oakland Rd. Bldg 3 Suite D.
Lawrenceville, GA 30044

Authorization for Release of Medical Records

Patient Name:_____ DOB: _____

Patient Phone Number: _____

I hereby by authorize the release of my protected health information to Zam Zam Family Cinic to (Release/Request) the following information: To provide copies of my medical records. The information may include other detailed information such as other mental health notes.

- ❑ Complete Medical Records
- ❑ Labs
- ❑ Diagnostic Testing
- ❑ Other: _____

Authorization to receive the disclosure you are authorizing Zam Zam Family Clinic to obtain Medicare records from below:

1._____
Name of Healthcare Provider / Other

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Fax

2. _____
Name of Healthcare Provider / Other

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Fax

_____
(Print Name)

_____ _____
(Signature) (Date)