Patient Registration Form

LiveWell
A PAIN MANAGEMENT & REGENERATIVE CENTER

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender	
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select):			Ethnicity (please select one):
☐ White	☐ American Indian or Alaska Native	☐ Asian	☐ Hispanic or Latino
☐ Hispanic	☐ Black or African American	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino
☐ Other	☐ Decline		☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to United Clinical Group's (UCG) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to UCG all money to which I am entitled for medical expenses related to the services performed from time to time by UCG, but not to exceed my indebtedness to UCG. I authorize UCG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from UCG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the PHMG Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to UCG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of United Clinical Group's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: **X** _____ **Date:** _____

Printed Name of Responsible Party: **X** _____ **Date:** _____

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

Height: _____ Weight:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please check all that apply)

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies, Seasonal
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bladder Problems / Incontinence
- ☐ Bleeding Problems
- ☐ Cancer: _____
- ☐ Headaches
- ☐ Crohn's Disease
- ☐ COPD/ Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: 1 or 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Attack (MI)
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Peptic Ulcer
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis

Last Menstrual Period	Date: _____	☐ Normal ☐ Abnormal
Colonoscopy	Yes No Date:____	☐ Normal ☐ Abnormal
Mammogram	Yes No Date:____	☐ Normal ☐ Abnormal
Dexa (Bone Density)	Yes No Date:____	☐ Normal ☐ Abnormal
Pap	Yes No Date:____	☐ Normal ☐ Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

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Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

☐ Alcoholism	☐ Bipolar Disorder	☐ Depression	☐ High Cholesterol	☐ Osteoporosis
☐ Anemia	☐ Cancer: _____	☐ Diabetes 1 or 2	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Kidney Disease	☐ Thyroid Disorder
☐ Arthritis	☐ Dementia	☐ Heart Disease	☐ Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

☐ Alcoholism	☐ Bipolar Disorder	☐ Depression	☐ High Cholesterol	☐ Osteoporosis
☐ Anemia	☐ Cancer: _____	☐ Diabetes 1 or 2	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Kidney Disease	☐ Thyroid Disorder
☐ Arthritis	☐ Dementia	☐ Heart Disease	☐ Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

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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.

- 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.
- We participate in one or more **Health Information Exchanges (HIE)** which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment.

This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

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, including most uses or disclosures of psychotherapy notes; for most marketing purposes. 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**.**

- 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.

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. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

I certify that I have read this Notice of Privacy Practices.

Patient Signature: _____ Date: _____