FAMILY PRACTICE/AFTER HOURS CLINIC 110 MILLSAPS DRIVE HATTIESBURG, MS 39402

FAMILY PRACTICE CLINIC WEST 7100 US Highway 98; Ste 140 Hattiesburg, MS 39402

www.fpahc.com

PATIENT REGISTRATION

PATIENT					
First Name	Middle Name	Last	Name		
			Marital Status		
Mailing Address		Street Address			
City	State		ZIP		
PATIENT EMPLOYMENT					
		Occupation			
Employer Address					
			710		
	State _		ZIP		
EMERGENCY INFORMATION Name of someone not living with you (in case)	se of emergency).				
Name		Relationship			
Contact Phone Number () Full Address					
Guarantor Information (if unde	er age of 19 or student				
Father Name					
Address:					
City State Zip			State Zip		
Contact Phone Number(s) ()			s) ()		
DOB Social Security #			ocial Security #		
Employer					
Employer		Employer			
FAMILY BILLING We would like to make your life easier with	our convenient family billing (or	ne patient statement per famil	y). This information also will allow our staff to discuss		
medical/billing information with those you au		parameter per fullil	,,,		
Name Relat	ionship	Name	Relationship		
	-				
Name Relat	ionship	Name	Relationship		

INSURANCE NAME & AUTHORIZATION ID: _____ DOB: ____ Guarantor Name: ___ ID: Secondary Ins: **CLINIC PAYMENT POLICY** **Lifetime Signature on File I, the undersigned, am responsible for payment of services rendered to me by The Family Practice/After Hours Clinic (Practice). (If patient is under 18, parent signing this form requesting treatment assumes finical responsibility.) Full payment is due at the time of service unless I am covered by an accepted commercial insurance or governmental coverage plan. I agree that if this account is not paid when due and the clinic should retain either a collection agency or an attorney for collection, I will pay a collection fee in the sum of 30% of the unpaid debt plus reasonable interest as permitted by law and court cost and attorney's fees incurred in collection of the debt. I give direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through varies means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer system, 4) voicemail messages, and other forms of communications. I authorize the Physicians and NP's of the Practice and its designees to provide treatment. I further authorize non-practice labs, radiology center, pathologist and radiologist who may interpret and/or report on diagnostic test to provide such treatment, if such tests are ordered by my Practice provider. DATE _____ SIGNED _____ RELATIONSHIP TO PT (IF PT IS A MINOR) ___ **INSURANCE AND/OR MEDIGAP** **Lifetime Signature on File I, the undersigned, authorize payment of medical benefits to this clinic, for any services furnished to me by the clinic. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release to my insurance company information concerning healthcare, advice, or treatment provided to me. This information will be used for the purpose of evaluation and administering claims of benefits. _ RELATIONSHIP TO PT (IF PT IS A MINOR) ___ DATE ___ SIGNED MEDICARE **Lifetime Signature on File □ I, the undersigned, understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any non-covered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made either to me or my behalf to this clinic for any services furnished me by the clinic. I authorize any holder of medical information about me to release to The Healthcare Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. SIGNED ___ RELATIONSHIP TO PT (IF PT UNABLE TO SIGN) **MEDICAID** **Lifetime Signature on File I agree to be responsible for any services not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this clinic. I authorize any holder of medical or other information about me to release to the Division of Medicaid or its Fiscal Agent any information needed to determine these benefits payable for related services. _____ RELATIONSHIP TO PT (IF PT IS A MINOR) ___ DATE SIGNED **FAMILY PRACTICE/AFTER HOURS CLINIC** ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices, Policies and Procedures. A copy of the clinics HIPAA policy can be found in the lobby, on the clinic website (www.fpahc.com) or you may request a copy at the front desk. Signature of Patient or Authorized Representative Date If authorized representative, relationship to patient The following people (parent, spouse, family member, etc..) are AUTHORIZED to my medical records. Name Relationship Name Relationship Name Relationship Name Relationship DO NOT RELEASE MY INFORMATION INCLUDING BILLING TO ANYONE OTHER THAN MYSELF $\ \Box$ I, the undersigned, understand that by choosing this option my provider/ clinic will not be allowed to discuss your medical or billing information with anyone other than you until you sign and date a release telling us otherwise.

Signed

Date

110 Millsaps Drive, Hattlesburg, MS 39402 your confidential medical recor (801) 261-5710 PLEASE PRINT Name: Age: Date of Birth: Sex: Parent/Guardian Name (if applicable): Decribe the nature of your visit today: What is the name of your preferred pharmacy/city? List any allergies & type of reaction List Medications/Drugs you have taken over the past 6 months Medication/Drugs you have taken over the past 6 months Medication/Drugs you have taken over the past 6 months Medication/Drugs Reason Taking How Long Taking Still Age: Date of Birth: Sex: List major illnesses or medical problems Your Past Medical History List surgeries or injuries Your Social History/Other Information Type of work occupation? Your Social History/Other Information Type of work occupation? Where did you go to school? Do you have an Advance Directive? Habits Smoke? Yos No How often? How long? How long? Light When? Reason Taking How long? Yes No How much per day? How long? How long? How long? Yes No How often? How long? How long? How long? Yes No How often? Women Only Date of last mentural cycle? Date of last mammagram? Number of pregnancies? Pregnancy Complications? Your Family History Has anyone in your immediate family (father, mother, brothers, sisters, children) had any medical problems? If so w	Today's Date		The Family Practice After Hours Clinic			Medical History Questionnaire This information will become a part of		
Name: Age: Date of Birth: Sex: Parent/Guardian Name (if applicable): Decribe the nature of your visit today: What is the name of your preferred pharmacy/city? List any allergies & type of reaction List Medications/Drugs you have taken over the past 6 months Medications/Drugs What is the name of your preferred pharmacy/city? List Medications/Drugs you have taken over the past 6 months Medications/Drugs What is the name of your preferred pharmacy/city? Vour Past Medical History List major illnesses or medical problems Your Past Medical History Your Social History/Other Information Type of work occupation? Where did you go to school? Do you have an Advance Directive? Habits They work occupation? How long? Jaffeine? Yes No How much per day? How long? How long? Jaffeine? Yes No How often? How long? Jaffeine? Yes No How often? How long? How long? How long? Jaffeine? Yes No How much per day? Jaffeine? Jafe of last memogram? Women Only Women Only Women Only How long? Hysterectomy? Age Your Familly History How preferred pharmacy/city?	And Andrews And Andrews Andrew	110 Millsaps Drive, Hatti	lsaps Drive, Hattiesburg, MS 39402		your confidential medical record			
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PAST MEDICAL HISTORY

ADD/ ADHD	YES	NO	Glaucoma	YES	NO
Allergies/ Sinus Trouble	YES	NO	Gout	YES	NO
Anemia	YES	NO	Headache/Migraines	YES	NO
Anxiety Disorder	YES	NO	Heart Attack	YES	NO
Arthritis	YES	NO	Heart Problems	YES	NO
Asthma	YES	NO	High Cholesterol	YES	NO
Bedwetting	YES	NO	Hypertension	YES	NO
Blood Disorder	YES	NO	IBS	YES	NO
Cancer	YES	NO	Insomnia	YES	NO
Chicken Pox	YES	NO	Kidney/Bladder Problems	YES	NO
Congenital Anomalies	YES	NO	Kidney Stones	YES	NO
Constipation	YES	NO	Liver Disease	YES	NO
COPD	YES	NO	Muscle, Joint or Bone Problems	YES	NO
Coronary Artery Disease	YES	NO	Osteoporosis	YES	NO
Depression	YES	NO	Prostate Trouble	YES	NO
Diabetes	YES	NO	Pulmonary Embolism	YES	NO
Diverticulitis	YES	NO	Seizures/Epilepsy	YES	NO
Ear or Hearing Problems	YES	NO	Skin Problems	YES	NO
Eczema, Hives or other Skin Issues	YES	NO	Stroke	YES	NO
Eye Disease or Injury	YES	NO	Thyroid Problems	YES	NO
Fibromyalgia	YES	NO	Tuberculosis	YES	NO
GERD	YES	NO	Ulcers	YES	NO

COORDINATION OF BENEFITS STATEMENT

If you have other insurance coverage in addition to another Commercial Plan, Federal Plan, Medicare, Medicare Advantage Plan, Medicaid, Magnolia MS CAN, UHC MSCAN or Ambetter, we will need that insurance information. As our patient, it is your responsibility to provide the Family Practice/After Hours Clinic with ALL Health Insurance you may have so we can guarantee that you receive the maximum benefits available from your insurance.

By selecting YES, you are legally stating that you have other insurance and have provided the Family Practice/After Hours Clinic with that information or by selecting NO, you are legally stating you have no other insurance.

By not providing all Health Insurance Information, it could be viewed as fraud by you; the patient. It may cause a delay in your claim being paid and possible make you responsible for any remaining balance that was denied due to being covered by another payer. So, please help us to better serve you by providing all Health Insurance.

Yes, I have other Health Insurance, that information has been listed on the Insurance Selection of the Registration Form or handed to a receptionist. Insurance cards have been presented to the Family Practice/After Hours Clinic reception staff.				
No, I have no other Health Insurance.				
Print Name				
Signature	Date			
** For Office Staff Only				
Staff Initials	Date			
Chart Number				