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 _____

SEX _____ DOB _____ Social Security # _____ Marital Status _____

Mailing Address _____ Street Address _____

City _____ State _____ ZIP _____

Home Phone( ) _____ Cell Phone( ) _____ Email _____

PATIENT EMPLOYMENT

Employer _____ Occupation _____

Employer Address _____ Work Phone ( ) _____

City _____ State _____ ZIP _____

EMERGENCY INFORMATION

Name of someone not living with you (in case of emergency).

Name _____ Relationship _____

Contact Phone Number ( ) _____ Full Address _____

Guarantor Information (if under age of 19 or student)

Father Name _____ Mother Name _____

Address: _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Contact Phone Number(s) ( ) _____ Contact Phone Number(s) ( ) _____

DOB _____ Social Security # _____ DOB _____ Social Security # _____

Employer _____ Employer _____

FAMILY BILLING

We would like to make your life easier with our convenient family billing (one patient statement per family). This information also will allow our staff to discuss medical/billing information with those you authorize.

_____ _____

Name **Relationship** **Name** **Relationship**

_____ _____

Name **Relationship** **Name** **Relationship**

OVER FOR INSURANCE AND SIGNATURES

INSURANCE NAME & AUTHORIZATION

Primary Ins: _____ **ID:** _____ **Guarantor Name:** _____ **DOB:** _____

Secondary Ins: _____ **ID:** _____ **Guarantor Name:** _____ **DOB:** _____

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.

DATE _____ SIGNED _____ RELATIONSHIP TO PT (IF PT IS A MINOR) _____

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.

DATE _____ 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.

DATE _____ SIGNED _____ RELATIONSHIP TO PT (IF PT IS A MINOR) _____

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 ☐

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.

_____

Date Signed

Today's Date ___/___/____	The Family Practice After Hours Clinic 110 Millsaps Drive, Hattiesburg, MS 39402 (601) 261-5710	Medical History Questionnaire This information will become a part of your **confidential** medical record

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/Drug	Reason Taking	How Long Taking	Still Taking

Your Past Medical History

List major illnesses or medical problems	Year	List surgeries or injuries	Year

Your Social History/Other Information

Type of work occupation?	
Education level that you completed?	Where did you go to school?
Marital Status	Do you have an Advance Directive?

Habits

Smoke?	Yes	No	How often? _____	How long? _____
Dip/Chew?	Yes	No	How often? _____	How long? _____
I quit! When? _____				
Alcohol?	Yes	No	How much per day? _____	How long? _____
I quit! When? _____				
Caffeine?	Yes	No	How much per day? _____	
Illicit Drugs	Yes	No	How often? _____	How long? _____
I quit! When?				

Women Only

Date of last menstrual cycle?	Date of last mammogram?	Number of pregnancies?
Age menstruation started?	Date of last PAP smear?	Pregnancy Complications?
Period every____days	Name of Physician?	Birth Control Method?
Flow lasts____days	Date of last bone density screening?	Hysterectomy? Age?

Your Family History

Has anyone in your immediate family (father, mother, brothers, sisters, children) had any medical problems? If so who?

Cancer	Heart Disease
Diabetes	Kidney Disease
Stroke	Thyroid Disease
High Blood Pressure	Arthritis/Gout
Anesthesia Reaction	Mental Illness or Suicide
Other illnesses that run in your family	

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 provicing 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