HealthCare Partners
Ph: (702) 255-3547
● Fx: (702) 736-2831

Patient Label

Patient Registration Form

Primary Care Physician _____ Referred by _____
Pharmacy Name _____ Pharmacy Phone _____
Pharmacy Cross Streets _____

Patient Information

Last Name _____ First _____ Middle _____
DOB _____ / ☐ M ☐ _____ / _____ Age _____ Gender: F Social Security
Number ☐ Single ☐ Married ☐ Divorced ☐ _____ - _____ - _____ Marital Status: Widowed
Primary Language _____
Race: _____ Ethnicity: ☐ Caucasian ☐ Latino/Hispanic ☐ Other ☐ Refused

Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____
Primary Phone to Contact: ☐ Home Phone ☐ Mobile Phone Email _____

Employer _____ Occupation _____
Work Address _____ Work Phone _____
City _____ State _____ Zip Code _____

Parent/Guardian Information

If Patient is a Minor (under the age of 18), please complete the following

Parent/Guardian Name _____ DOB _____ / _____ / _____
Parent/Guardian Relationship to Patient: _____ Gender: ☐ M ☐ F
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Employer _____ Occupation _____

Emergency Contact

Name _____ Relationship to Patient _____
Home Phone _____ Mobile Phone _____ Work Phone _____

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Name
_____ Relationship to Patient _____
Home Phone _____ Mobile Phone _____ Work Phone _____

Insurance Information

Primary Insurance

Policy Effective Date _____ / _____ / _____ Insurance Phone Number _____
Insurance Company Name _____
Member ID _____ Group ID _____
Claims Mailing Address _____
City _____ State _____ Zip Code _____

Subscriber Name _____ DOB _____ / _____ / _____
Social Security Number _____ - _____ - _____ Gender: ☐ Male ☐ Female
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Employer _____ Occupation _____

Secondary Insurance

Policy Effective Date _____ / _____ / _____ Insurance Phone Number _____
Insurance Company Name _____
Member ID _____ Group ID _____
Claims Mailing Address _____
City _____ State _____ Zip Code _____

Subscriber Name _____ DOB _____ / _____ / _____
Social Security Number _____ - _____ - _____ Gender: ☐ Male ☐ Female
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____ Work Phone _____
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By signing this document I confirm the information provided to Healthcare Partners and its authorized representatives is true and correct. I also authorize the release of all information necessary to file a complete claim with the insurance company of record. I authorize and assign all eligible benefits to be paid to Healthcare Partners. In the event that insurance does not cover any or all charges, I understand that I am financially responsible for all charges for all medical services rendered to the above named patient.

I understand there is a $25 non-sufficient fund (NSF) fee for returned checks.

In the unfortunate event that my account is sent to a 3rd party collection agency, I understand that I am responsible for collection/legal fees.

Patient/Guardian Signature _____ Date _____

Acknowledgement of Health Insurance Portability and Accountability Act (HIPAA) and Confidential Communications

I am aware that the Privacy Practices Notice is posted in the main lobby for my review and that I have the right to a copy at my request.

The HIPAA privacy rule allows patients the right to place a restriction on uses and disclosures of their protected health information (PHI). Additionally, patients have the right to request confidential communications or that a communication of PHI be made by alternative means.

I wish to be contacted in the following manner: (Check all that apply)

Methods selected below do not apply to Appointment Reminders.

☐ Home Phone
OK ☐ to leave message with detailed information Work Phone ☐
Leave ☐ message with call back number only OK to leave message with ☐ detailed information
Leave ☐ message with call back number only ☐

☐ Mobile Phone
OK ☐ to leave message with detailed information Written ☐ Communication
OK to text ☐ detailed information OK to mail to my home address ☐
Leave ☐ message with call back number only OK to Email to: ☐ _____ Text message ☐ with call back number only

Patient Portal Communication Notification: By registering for the Patient Portal, the patient has given the practice permission to communicate detailed information through secure messaging. The patient will have to log in to the portal using their personal

Patient Label

username and password to read any secure messages that are received. To learn more about the Patient Portal, please speak to the front office staff or visit https://mywellhealthqc.portalforpatients.com to register.

I authorize the release of all my protected health information to:

Name _____ DOB _____ / _____ / _____
Relationship to Patient: ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other: _____
Home Phone _____ Mobile Phone _____ Work Phone _____

Name _____ DOB _____ / _____ / _____
Relationship to Patient: ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other: _____
Home Phone _____ Mobile Phone _____ Work Phone _____

Print Patient Name _____ DOB _____ / _____ / _____

Patient Signature _____ **Date** _____

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Notice of Insurance Coverage and Benefit Acquirement

Healthcare Partners is aware that navigating the healthcare system can be frustrating and difficult. However, we want our patients to be informed regarding all financial obligations directed towards the insurance company, patient, or subscriber (the person insured).

Healthcare Partners will attempt to gather and verify the most current information we have regarding your insurance coverage prior to your visit. However, benefits can change frequently and we want our patients to understand their medical benefits and any out-of-pocket costs.

What can you do to prevent and financial hardships? Please review the questions below and then familiarize yourself with your specific coverage. This information is available through your insurance company's information booklet or their website. Sometimes these sites only have general information, so we highly recommend you call your insurance company and ask about the specifics of your plan.

Regardless of your medical insurance coverage, please be assured that your health care provider will determine the best treatment plan for you.

Vital information you should know about your insurance benefits:

- ☐ Who is my primary care provider?
- ☐ Does my insurance company consider Healthcare Partners Women's Care as a primary care provider or a specialist? (This may affect your co-pay amount.)
- ☐ Is my doctor a provider on my insurance?
- ☐ How much is my co-pay and/or deductible?
- ☐ Have I met my deductible?
- ☐ Do I need a referral to see a doctor other than my primary care provider (PCP)?
- ☐ Are there any limitations on where I can obtain lab tests?
- ☐ Do I need prior authorization for procedures or planned hospitalizations?
- ☐ Do I have a pre-existing condition my insurance will not cover?

Please be aware that the above information is vital and you are equally responsible with Healthcare Partners to understand and confirm your insurance benefits.

Print Patient Name _____ DOB _____ / _____ / _____

Patient Signature _____ **Date** _____

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