apollo Physicians

8191 Timberlake Way, Suite 200
Sacramento CA 95823
Phone: (916) 236 5800 Fax: (916) 244 4498

Registration Form

PATIENT INFORMATION

Name: Last ______________________________ First ____________________ MI ____

Date of Birth: ____/____/____ Social Security Number:_______________________

Email: ___________________________________

Sex: ☐ Male ☐ Female ☐ Transgender **Patients Preferred language?** _____________________________

Home Address: ____

City: ________________________ State: ______ Zip _____________

Home Phone #: (_____) _________-__________. Ok to leave message? _______

Cell #: (_____) _______-____________ Ok to leave message? _______

Work #: (_____) _______-___________ext._____

Pharmacy Name: ____________________________ Phone # (____) ___ - ______

EMERGENCY CONTACT

Name:___________________________________ Home Phone #: (_____)______ - ______________

Relationship: ____________________________ Work Phone #: (_____)______ - ______________

Address: ____

RESPONSIBLE PARTY (If patient is a minor complete this section)

Name: Last ____________________________________ First ________________________ MI__________

Address: (if different): ____________________________City: _______________ State: _____ Zip __________

Home Phone: #: (___)_____-_____Work Phone #: (___)_____-_____Date of Birth of Guardian: __/__/__

Social Security of Guardian: __________________ Relationship to patient: ☐Mother ☐Father ☐Other__________

PATIENT INSURANCE INFORMATION

Name of Insured	Primary Insurance Company Name	Secondary Insurance Company Name
Relationship to Patient	ID #	Group #

CONSENT

In order to provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and by providing your signature below.

1. **Consent for Treatment:** I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself (or child/dependent stated above) while a patient at Apollo Physicians Medical Group. ______ **(initials)**
2. **Release of Information:** I authorize the release of medical information necessary to process billing claims related to my care. ______ **(initials)**
3. **Assignment of Benefits:** I authorize payment of medical benefits to Apollo Physicians Medical Group for professional services rendered. ______ **(initials)**

Your signature below indicates you have read, understand and agree to the payment policy, and consents.

Signed: ___________________________________ **Date:** __________________________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ________________________________ Date of Birth: ________________

I hereby authorize medical providers and personnel of Apollo Physicians Medical Group to discuss my protected health information with:

____ ____
Name Relationship

____ ____
Name Relationship

____ ____
Name Relationship

Please indicate information to be released or discussed:
I understand that certain information cannot be released or discussed without specific authorization as required by state of federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ All Information including;
_____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment for alcohol or drug abuse
_____ Ability to makes or confirm appointments only
_____ Pick up Prescriptions/Medications
_____ Genetic Testing

This authorization shall be in force and in effect from ____________ until ____________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire after one year.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use of disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

____
Signature of Patient/Personal representative Name of Patient/Personal Representative

____
Description of Personal Representative's Authority Date

____
Refused Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Healthcare operations which include the business aspects of running our practice. Examples of this would include having a sign in sheet, calling to confirm appointments, leaving messages on your recorders regarding appointments, sending reminder/appointment cards in the mail with our practice name on them, using yours or a family members' first and last name while servicing you in our office, discuss with/allow immediate family members/guardians into the exam process to allow for better understanding of treatment options when necessary.

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________

Relationship to Patient: ____________________________

Signature: ____________________________ Date: _______

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so, I documented the reason below:

Date: ______________________ Employee Initials:___________________________

Reason:____

Patient Rights and Responsibilities

As a patient of Apollo Physicians, you have the right to:

- Considerate and respectful care, without unlawful discrimination
- Know the name and professional qualifications of the medical providers involved in your treatment
- Choose your medical provider(s)
- Receive accurate, understandable information regarding any proposed treatment or procedure in order to make an informed health care decision.
  Information provided shall include:
  - A description of the treatment or procedure.
  - The medically significant risks involved.
  - Alternative courses of treatment or non-treatment and the risks involved in each.
- Fully participate in decisions regarding your medical care
- Confidentiality and the protection of privacy concerning your medical care program and medical records or other personal health information. You have the right to be advised as to the reason for the presence of any individual present during examinations or during discussions about your medical information.
- Access, review, and/or copy your medical records in accordance with applicable law
- Receive an itemized bill for services and an explanation of charges, including services that will be charged to your insurance, as applicable
- Have complaints or concerns reviewed in accordance with our established process, without fear of retaliation or sanction.

As a patient of Apollo Physicians, you assume responsibility for:

- Being considerate and respectful to our staff and your fellow patients
- Providing accurate and complete information concerning your present medical concerns, past medical history, and other matters relating to your health
- Participating and working collaboratively with your medical providers in developing your treatment plan
- Making it known whether you understand your medical treatment and what is expected of you
- Following the treatment plan established by the medical providers involved in your care
- Keeping appointments and notifying the office in a timely manner if you are unable to keep an appointment
- Abiding by our policies and procedures, as well as those of any applicable insurer or government benefits program
- Providing accurate and correct demographic and financial/insurance information
- Fulfilling the financial obligations related to your treatment
- Supervising your children while in the Health Center (if a parent or guardian)

I have read and understand the Patient Rights and Responsibilities:

Patient/Guarantor Signature: ______________________________ Date: ______________

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

AUTHORIZATION

I hereby authorize: ____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To:
Apollo Physicians Medical Group
8191 Timberlake Way Suite #200
Sacramento, CA 95823

The medical information/records will be used for the following purpose: ___________________________

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information from: _______ to ________ .

DURATION: This authorization shall be effective immediately and remain in effect until _________Date.

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_______________________________________ _______________________________
Signature of patient *or legal/personal representative* Relationship *if other than patient*

______________________________________ _______________________________
Patient's Name (PRINT) Date

____
Patient's Date of Birth