Patient Registration Form

Date of Appointment: .....

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address , ,

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company(ies) and assign directly to Dr. William Boulware or Dr. Robert Boulware all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient or Authorized Guardian

Date

Boulware Medical Clinic, L.L.C.

Board Certified Internal Medicine

William T. Boulware, M.D.
Robert J. Boulware, M.D.

Patient Request for Email Communications

Patient Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email. To request that this provider/program communicate with you via email you must complete this form and return it to your health care provider's office.

Please be advised that:

- **This request applies only to the healthcare provider or program that you indicate below.**

If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.

- Boulware Medical Clinic will not communicate health information that is specially protected under state and federal law (*e.g.*, HIV/AIDS, substance abuse, mental health information) via email.

- You must provide your email address when registering for your visit with your provider

- It is recommended that you send a test email before corresponding via email.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated via email.
- I understand that all email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Boulware Medical Clinic and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature of patient _____ **Date** _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

BOULWARE MEDICAL CLINIC

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is "friendly" version. A more complete text is posted in the office and is available at any time for your review.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1) Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Your medical records will not be made available to anyone other than office staff without your explicit written permission. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2) It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, mail of by any means convenient. We also send out communications regarding results from testing via telephone and US mail.
3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4) You understand and agree to inspections of the office and review of documents which may include PHI by government or insurance payers in the normal performance of their duties.
5) You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
6) Your confidential information will not be used for the purposes of marketing or advertising.
7) We agree to provide patients with access to their records in accordance with federal and state laws.
8) We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9) You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set for the in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand this consent shall remain in force from this time forward.

____I give permission to Boulware Medical Clinic to communication with me via the US Mail regarding test results.

____ I request communications regarding to test results not be mailed to me.

_____

Printed Name and date of birth

_____

Signature

Date: _____