Registration Form *ColoRectal Consultants*

PATIENT INFORMATION

Last Name:	First Name:	Middle:	Gender: M ◯ F ◯

Address:	City:	State:	Zip:

Date of Birth:

Home Phone:	Cell phone:	Work Phone:

Social Sec #:	Email:

Occupation:	Race:

Referred by:	Phone #:	Fax #:

Primary Care Physician:

INSURANCE INFORMATION

Please indicate primary insurance:

Policy Holder's name:	Patient Policy #:	Group #:	Ins Phone #:

Name of secondary insurance (if applicable):

Policy Holder's name:	Policy #:	Group #:	Ins Phone #:

PHARMACY INFORMATION

Pharmacy:

Address:	City:	State:	Zip:	Phone #:

EMERGENCY CONTACT

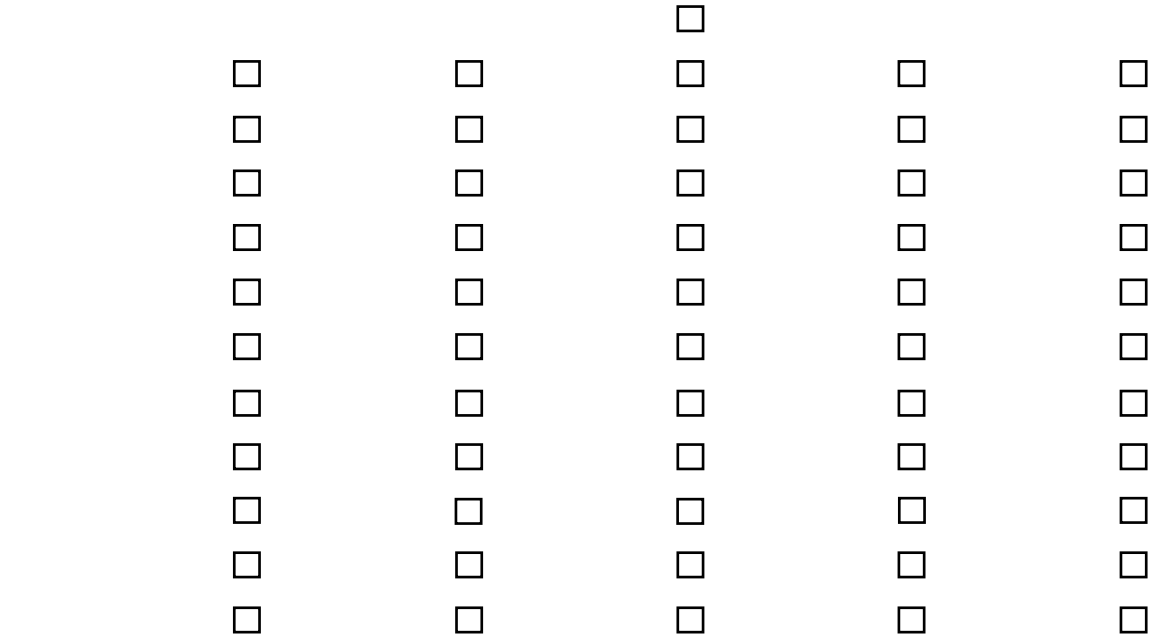
Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #:

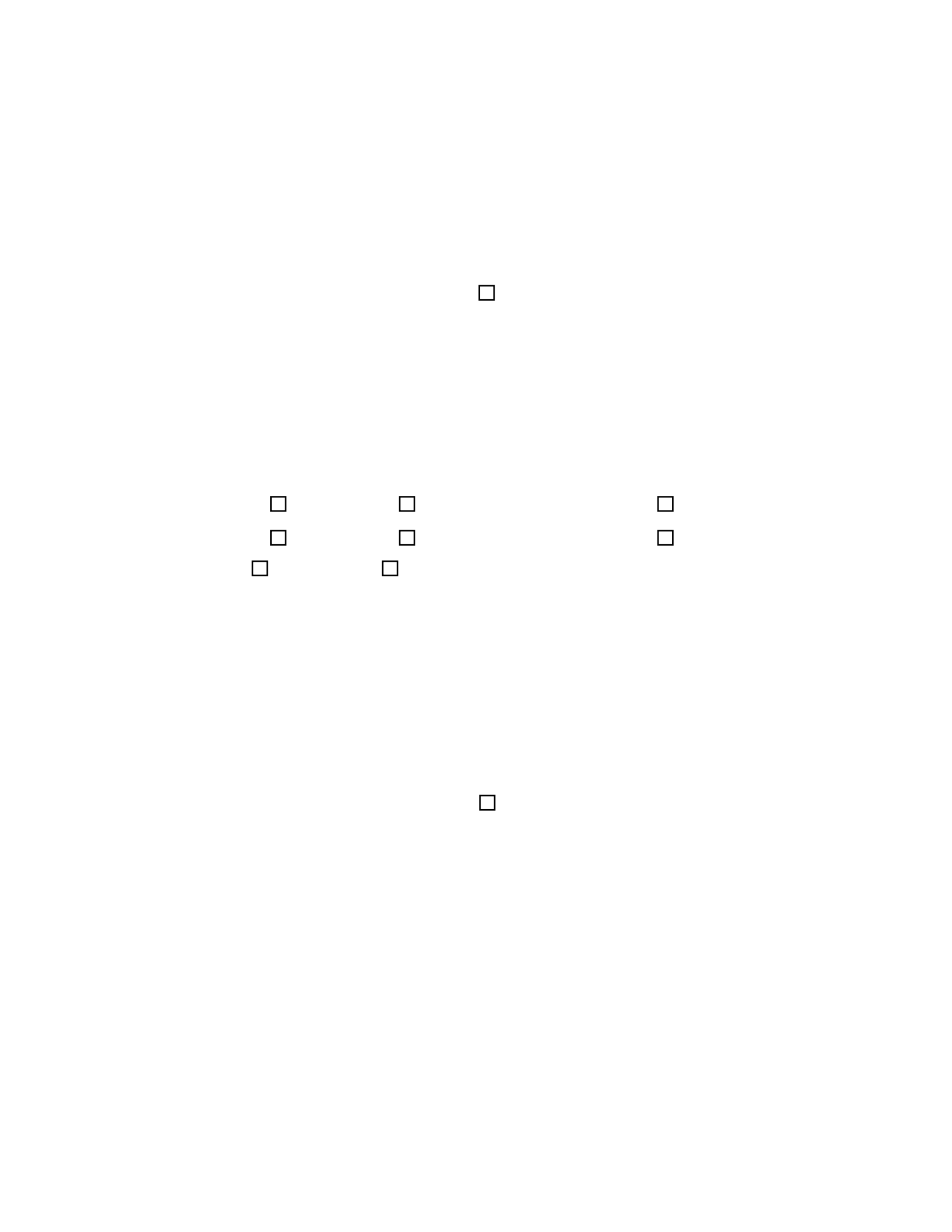
I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for all charges whether or not they are paid by insurance. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, my account(s) may be referred to a collection agency and I will be responsible for all attorney's and/or collection fees.

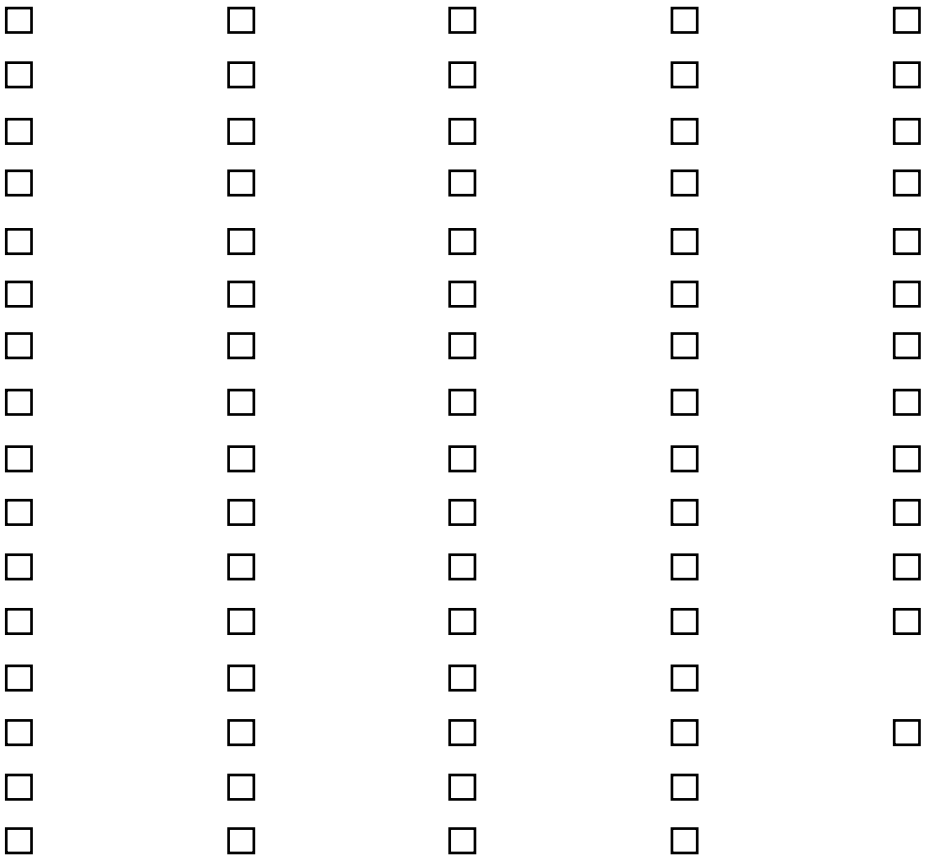
I authorize ColoRectal Consultants or its representatives to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I further agree that a photocopy of this agreement shall be as valid as the original.

I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request. I have read and understand the information on this form.

Patient/Guardian signature:	Print Name:	Date:







NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Ace of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information. We may use and disclose your medical records only for each of the follow purpose: treatment, payment, and health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide reminders or information about treatment or other health-related benefits and services that may be of interest to you. Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notices of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Patient Signature: _____

For more information about HIPAA, or to file a complaint, please contact:
The U.S. Department of Health and Human Services, Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C., 20201 | (202) 619-0257 | Toll Free: 1-877-696-6775

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Medical Information	Billing information
Dr._____	_____
Dr._____	_____
Spouse _____	_____
Other_____	_____

I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office.

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

Patient Name:_____

Signature:_____ Date:_____