Today's Date _____/_____/_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one)	City	State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy: Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number
			( )

INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO **Insurance Name**

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number
		( )	( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date

HEALTH HISTORY

Name: _____ Birthdate: _____

Today's date: _____ Date of last physical examination: _____

SYMPTOMS - Check (✓) symptoms you currently have.

GENERAL
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Decrease in exercise capacity

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation or diarrhea
- ☐ Gas
- ☐ Heartburn or indigestion
- ☐ Hemorrhoids
- ☐ Nausea or vomiting

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

MUSCLE / JOINT / BONE
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

NEUROLOGICAL
- ☐ Dizziness or lightheadedness
- ☐ Weakness
- ☐ Fainting
- ☐ Seizures

PSYCHIATRIC
- ☐ Depression
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Stress
- ☐ Trouble concentrating

ENDOCRINE
- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid disease

HEMATOLOGICAL
- ☐ Anemia
- ☐ Bleeding disorder

ALLERGIES
- ☐ Asthma
- ☐ Hay fever or allergic rhinitis

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period _____

Date of last pap smear _____

Have you had a mammogram _____

Are you pregnant? _____

Number of children _____

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge

CONDITIONS - Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Psychiatric care
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease

Please complete the back of this form also.

PAST MEDICAL HISTORY - List surgeries you have had and the year.	
1.	2.
3.	4.

MEDICATIONS: List medications you are currently taking.		ALLERGIES: To medications or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:	Phone: ( )	

Fill in health information about your family				
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

PREGNANCY HISTORY:

Year of Birth	Sex of Birth	Delivery Type	Complications if any

SOCIAL HISTORY:

Check (✓) the substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Alcohol	
	Other	

SOCIAL HISTORY:

List any illnesses that run in your family.	
1.	5.
2.	6.
3.	7.
4.	8.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Physician Signature _____ Date reviewed _____

AMG-Livingston, LLC

HIGHPOINT HEALTH SYSTEM

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my

primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form

of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

AMG-Livingston, LLC

HIGHPOINT HEALTH SYSTEM

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____
Witness (Staff) Signature

_____
Witness (Staff) Printed Name

Date: _____

This Facility and its affiliates comply with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

LIVINGSTON ORTHOPEDICS & SPORTS MEDICINE

Formulary Benefits Date Consent Form

Formulary Benefits data are maintained for health insurance poroviders by organizations known as Pharmacy Benefits Managers (BPM). BPM's are third party administrators of prescription drug programs whose primary responsibilities are processsing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permision for Livingston Orthopedics and Sports Medicine to access my pharmacy benefits data electronically through surescripts. This consent will enanble the office to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan. Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions by other providers using surescripts.

_____ _____

Patient name Date of Birth

_____ _____

Patient/Guardian signature Date