Patient Registration Form

Cole Surgical Arts PC

Patient Information

Patient Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Last Name:	First Name:	M.I:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐Male ☐Female	
Marital Status:	Social Security #:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information

Email Address:	Would you like to be set up for patient portal? ☐ Yes ☐ No
How did you hear about us (please select one): ☐ Billboard ☐ Family or Friend ☐ Newspaper or Magazine ☐ Other ☐ Patient ☐ Radio Ad ☐ Referring Provider ☐ Social Media	Preferred Language (please select one): ☐ English ☐Indian (including Hindi & Tamil) ☐ Other ☐ Sign Language ☐ Spanish
Race (please select): ☐ American Indian or Alaska Native ☐ Asian ☐ Decline ☐Other ☐ Black or African American ☐Hispanic ☐White ☐ Native Hawaiian or Pacific Islander	Ethnicity (please select one): ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline
Employer Name:	
Preferred Pharmacy Name & Location:	
I give permission to obtain all my/the patient's medication/ prescription history when using an electronic system to process prescriptions for my medical treatment. ☐ Yes ☐ No	

Release of Information

Authorization for Release of Information

Emergency Contact Name:	Emergency Contact Phone #:
Relationship to Patient:	
May we leave testing results, referral information or other medical information via voicemail or email? ☐ Yes ☐ No	
Who may receive or request information on your behalf regarding your medical care, results, or referrals?	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Consent

Consent to Treat
I voluntarily consent to all health care treatment provided by Cole Surgical Arts and its physician, clinicians, and other personnel. I am aware the practice of medicine is not an exact science and I further state that no guarantee has been or can be made as to the results of the treatment or examinations.

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Cole Surgical Arts financial policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Cole Surgical Arts all money to which I am entitled for medical expenses related to the services performed by Cole Surgical Arts. I authorize Cole Surgical Arts to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims.

If I choose to receive communications from Cole Surgical Arts by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made Cole Surgical Arts. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Cole Surgical Arts PC Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: **X** _____ **Date:** _____

Printed Name of Responsible Party: **X** _____ **Date:** _____

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Financial Policy

Cole Surgical Arts participates with most insurance plans. However, each insurance policy is different, and it is difficult to know benefit details for all carriers. Contact your insurance company if you have any questions regarding benefits and payment obligations.

Copayments and Deductibles
All co-payments, co-insurance, and deductible amounts are due and payable at the time of service.

Returned Check
There is a $40.00 charge for returned checks.

Patients Without Insurance Coverage and Self-pay
Self-pay accounts are those covered by carriers the practice does not participate, patients without insurance, or patients who have not met their deductible.

Unpaid Balance
Unpaid balances over 90 days old, without payment arrangements, may be sent to collections. You will also be responsible for any additional amounts incurred for collecting past-due balances. Payment plans will incur interest.

Letters and Forms
As a courtesy to our patients, we fill out forms. However, we charge for the following:
Letter or simple form (other than regular work/school excuse) - $10.00 per letter or simple form
Forms: FMLA, Short-term Disability, etc. - $20.00 Per set

Medical Record Release Fees
Requests for copies of medical records must be made in writing to the clinic. We will fax medical records to a provider of your choice free of charge. However, if you need a copy from us, you will be charged reasonable costs of reproducing the record as provided by applicable law.

Referrals
Some insurance carriers require referral from your primary care provider. If this authorization is not provided, you will be rescheduled or pay for your visit at the time of service.

If you have any questions or need clarification of any of the policies, please contact our business office.

I have read and I understand the above policy and agree to it in its entirety.

_____ _____

Signature of Patient (Legal Guardian) Date

_____

Name of patient

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Office Policies-2021

Scheduling an Appointment:
Appointments can be scheduled by calling our office at (256) 273-4300 during office hours (Monday to Thursday from 8:00 am to 5:00 pm). We have same-day appointments for most visits; please call early in the day if you need to be seen the same day.

Cancellation Policy/ No Show Policy:
To help our office function as efficiently as possible, we request 24 hour notice to cancel an appointment. This allows us to open up the slot for another patient.

Late Policy:
We strive to adhere to time, unfortunately delays do occur. Patients arriving 15 minutes after their scheduled appointment time may be asked to re-schedule or wait longer.

Prescription refill:
All medication refills for chronic conditions are handled during office visits. We recommend patients bring all medications to each visit.
If patient is due for follow-up or preventative care, we may need to schedule these visits prior to refilling prescriptions and can address medication needs at that time.
We cannot call in controlled substance prescriptions and require office visit for thorough evaluation.

Telephone Calls:
Our knowledgeable clinic staff is here to answer any questions you may have. During our office hours, you can call our office at (256) 273-4300 to speak to a nurse. Our staff generally returns phone calls at the end of the morning clinic session and in the evenings.

If you need emergency service, please call 911 or go to your nearest emergency department.
If you have an urgent medical issue after clinic hours, weekends or holidays, please call (256) 845-3150 and request for Dr Cole to return your call.

_____ _____
Signature of Patient (Legal Guardian) Date

_____
Name of patient

Rev. 2021

Cole Surgical Arts, PC
323 Medical Center Drive SW
Fort Payne, AL 35968

Authorization to Use and Disclose Protected Health Information

Patient Name:_____DOB:____/_____/_____

I authorize the use or disclosure of the above-named individual's health information as described below to/from

Cole Surgical Arts, PC
323 Medical Center Drive SW
Fort Payne, AL 35968

Agency or Individuals Authorized to release my Health Information to/from:

☐ Treatment/ Ongoing medical care ☐ Coordination of care

Doctor/Clinic/Hospital:_____

Address:_____

Telephone Number:_____Fax Number: _____

Please release the following:

☐ **All Health Information**

☐ History/Physical Exam ☐ Discharge Summary ☐ Lab and path report(s)

☐ Progress/Consultation Notes ☐ Diagnostic Tests ☐ Other (specify):

I also consent to the specific release of the following records:

☐ Drug, alcohol, substance abuse ☐ Psychiatric/Mental Health

☐ Tests for HIV/AIDS/STD ☐ Genetic Testing

This authorization will expire 1 year after the date of signature below, unless earlier date is specified. I understand I have the right to revoke this authorization at any time, in writing, except where the disclosure has already been made.

A photocopy or facsimile of this authorization shall be considered as valid as the original.
I have been advised of my right to receive a copy of this authorization.

Signature:_____ Date:_____/_____/_____

Print Name:_____ Relationship to Patient: _____

Witness Name:_____ Witness Signature: _____

Please fax records to 256-979-1017. If you have any questions, please call us at 256-273-4300.