HONORHEALTH™

Medical Group

New Patient Registration – Demographics and Insurance

Patient: Name/First ________________Middle____________________Last______________________

SSN: ______-_____-_______ Date of Birth: ______/_______/_____ Sex: M | F

Patient street address: ____

Patient address additional: ____

City: ___________________________ State: _________ ZIP: _____________-__________

Primary Phone Number: (_______) _______-_____________Mobile | Home | Work

Secondary Phone Number: (_______) _______-_____________Mobile | Home | Work

Email address: ____

What is your primary language? ______________________ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

Religious preference: ___________________________ ☐ I prefer to not answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   _____Hispanic or Latino _____ Not Hispanic or Latino
   _____ I prefer to not answer.
2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? ____

Name of the primary care practice: ____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: ___________________________________

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don’t know

Patient Name: First__________________ Middle_________ Last______________________ Date of Birth: ____/_____/_____

Who would you like to list as an **emergency contact**?

Name: ____

Address: ____

____

Relationship to you: ____

Phone Number: (_______) _______-_____________ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write “self” if you are financially responsible.

Guarantor: Name/ First___________________Middle________________Last_____________________

SSN: _______-_______-________ Date of Birth: ________/_______/_______ Sex: M | F

Address: ____

____

Phone Number: (_______) _______-_____________ Mobile | Home | Work

Medical Insurance Company Name: ____

Member/Subscriber Identification #: ______________________ Group #: ___________________________

Medical Insurance Company Address: ____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _________________

Subscriber: Name/ First___________________Middle_________________Last____________________

SSN: ________-_______-________ Date of Birth: ________/______/_______ Sex: M | F

Address: ____

____

Phone Number: (_______) _______-_____________ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.

HONORHEALTH

Confidential Communications Form

This form helps us understand how you want us to communicate with you, or others, about the care we provide you. You can choose what modes of communication you would like us to use and who we can share information with. We may need to communicate test results, prescription information or respond to a message you left with your physician's office. By completing this form, you understand the following:

- This form gives us permission to communicate with you in a manner that you choose.
- You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone. If you want anything changed on this form, it is your responsibility to contact us to complete a new form. You will be asked to review or update this form at least annually on your next visit to our office.
- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, medications, diagnoses, procedures, etc.
- You understand that your decisions on this form apply to communications made to or from HonorHealth physician offices and not in other locations within HonorHealth (e.g., inpatient hospital).
- You have received a copy of HonorHealth's *Notice of Privacy Practices* and understand other ways HonorHealth can use or disclose your health information not otherwise listed on this form.

Patient Name: ____ MRN: ______________

Please tell us how you would like us to communicate information to you by checking all the boxes that apply:

☐ You may contact me by telephone/text/voice mail: **Cell** ☐ **Home** ☐ (_____) ______ - ________

☐ You may contact me by e-mail. E-mail address: ______________________________________

Please list the name(s) of the person(s) below who you give us permission to communicate your health information and the kind of information you permit us to communicate:

Name and Phone Number	This person's relationship to you	Information we can share (check box)
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information

By signing below, you allow us to communicate your health information to you, and permit us to share your health information with other persons, as indicated above.

Patient Name (Please Print)	Patient Signature	Date of Signature
Patient's Legal Representative (if patient can't sign) (Please Print Name)	Patient's Legal Representative Signature	Date of Patient's Legal Representative Signature

COLLABORATING FOR PAIN MANAGEMENT

Patient Name:____ **MRN:**_______________

Provider Name:____

Patient Waiver for Non-Covered Services

Your medical provider recommends the service/procedure listed below as medically necessary for your care. We expect your insurance may not pay and we want you to understand that you may have to pay for them yourself.

Service/Procedure	Reason Insurance May Not Pay:	Estimated Cost
80307-Testing for presence of drug, by chemistry analyzers	Your insurance may find this test to be not medically necessary	$186.00

Additional Information:

This waiver pertains to the service/procedure performed by your treating doctor. There may be additional providers, such as a pathologist who works at a laboratory, who may also bill you.

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- If you have other questions on this notice, please contact your insurance.

YES: Signing below means I have read and understand this notice and agree to pay for this service/procedure myself and am personally and fully responsible for payment if my insurance denies payment to my doctor(s). I have also received a copy.

Signature of Patient (or representative):	Date:

NO: I decline to pay for this service/procedure and understand that my provider may choose not to provide them because I have not agreed to pay.

Signature of Patient (or representative):	Date: