Welcome to Metro Medical Practice, P.C.
REGISTRATION FORM

Our office has implemented a new policy of requesting all the following information below.
ALL FIELDS REQUIRED.

Last Name: _____ **First Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

(Please circle best number to reach you during the day)

Home Ph: (___) _____ **Cell:** (___) _____ **Work:** (___) _____

Date of Birth: M____D____Y____ **Social Security #:** _____/_____/_____ **Sex:** ☐ **Male** ☐ **Female**

E-Mail Address: _____ ☐ **DO NOT HAVE E-MAIL**

In Case Emergency Person to Call: _____

Relationship: _____ Phone: (___) _____

Pharmacy Name: _____ **Pharmacy Ph#:** _____

Pharmacy Address/City/Zip: _____

Insurance: _____ ☐ **NOT INSURED**

Subscriber's Name: _____ Subscriber's DOB: M____D____ Y_____

Relation to Patient: _____

Allergies: _____

Preferred Language:	**Race:** ☐ **Asian**
☐ **English**	☐ **American Indian/Alaska Native**
☐ **American Sign Language**	☐ **Black/African American**
☐ **Arabic**	☐ **Native Hawaiian/Pacific Islander**
☐ **Bengali**	☐ **White/Caucasian**
☐ **Chinese**	☐ **Prefer not to answer**
☐ **Japanese**	
☐ **Polish/Ukrainian/Slavic**	**Ethnicity:** ☐ **Hispanic**
☐ **Spanish**	☐ **Not Hispanic**
☐**Other**_____	☐ **Prefer not to answer**
☐ **Prefer not to answer**	

PRESCIPTION MEDICATION CONSENT

The providers at Metro Medical Practice P.C. use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Surescripts) which improves the timely and accurate transmission of your medication information.
To optimize the use of this electronic capability, and coordinate your care between us and your specialist, we ask that patients allow us to access their medication history through the RX History.
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

- MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

☐ **Authorize** ☐ **Deny**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Metro Medical Practice or insurance company to release any information required to process my claims.

Patient/Guardian Name (PRINT) _____ **Date:** _____

Patient/Guardian Signature: _____

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 a "friendly" version. A more complete text is posted in the office.

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 care 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. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . 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, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

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 agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the 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, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.