Patient Registration Form

Clearfield Medical Group

Patient Information

Last Name:	First Name:	Previous Name
Mailing Address:		Apt #
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact for Reminder Calls:		Please Select Preferred Number: Home Cell Work
Family Physician or Pediatrician:	Date of Birth:	Sex: Male Female
Marital Status:	Social Security #:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:		Relationship to Patient:

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 (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	Can we leave a message regarding your medical care & test results?
Race (please select): O White O American Indian or Alaska NativeO Asian O Hispanic O Black or African American O Native Hawaiian or Pacific Islander O Other O Decline	Ethnicity (please select one): O Hispanic or Latino O Not Hispanic or Latino O Decline
Preferred Language (please select one): O English O Bosnian O Indian (including Hindi & Tamil) O Sign Language O Spanish O Russian O Other	
Preferred Pharmacy Name & Location:	

Primary Insurance	Secondary 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 Clearfield Medical Group (CMG) payment 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 CMG all money to which I am entitled for medical expenses related to the services performed from time to time by CMG, but not to exceed my indebtedness to CMG. I authorize CMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from CMG 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 to CMG. 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 Clearfield Medical Group's Privacy Notice. ☐ (Initials)

Signature of Responsible Party: x _____ Date:

Printed Name of Responsible Party: x _____ Date:

Dr. William N. Clearfield D.O.

FINANCIAL POLICY

9550 S McCarran Blvd Suite B Reno, Nevada 89523
Phone: (775) 359-1222 Fax: 888-977-3503

Dr. William N. Clearfield D.O. believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company; payment will be collected at check-in.

If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of your insurance card and an ID that is government issued due to the many cases of identity theft.

INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full**. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for full payment; It is the responsibility of the patient to know if we are contracted with their insurance plan or not. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.
Not all insurance plans cover all services; in the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our billing office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

RETURNED CHECKS will incur a $25.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $25 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $25 service fee and collections action. All bad checks written to this office are subject to an outside collection agency.

ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORMS FEES: completing insurance forms, dmv/NDOT forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms as most insurance companies do not cover these types of charges; copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance.

BILLING OFFICE: If you have questions in regard to any of your billing statements, our billing office, CMG is available to assist you. Copying fees for Medical Billing Records is $10 for the first twenty (20) pages and $0.60 per page in excess of twenty. Our billing office will have 15 business days in which to copy records before mailing them to the patient, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release. CALL 775-359-1222 **office hours Monday through Friday 8am to 5pm Pacific time.**

Dr. William N. Clearfield D.O.

FINANCIAL POLICY

9550 S McCarran Blvd Suite B Reno, Nevada 89523
Phone: (775) 359-1222 Fax: 888-977-3503

CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $35 missed appointment fee.

PATIENT INFORMATION: It is the responsibility of the patient to notify our office of changes in address, phone number, insurance coverage (including effective and termination dates). Insurance charges that are returned to our office as coverage termed, not effective on the date of service will result in the patient being billed for all services received. Patient statements returned to our office as "undeliverable" or "moved with no forwarding address" will result in an attempt to contact the patient one time by telephone. If the patient is unresponsive (within 48 hours of initial phone call to patient) to attempts to contact and get updated information, all outstanding balances will be sent to an outside collection agency.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **Dr. William N. Clearfield D.O.** for charges not covered by the assignment of insurance benefits.

ASSIGNMENT OF INSURANCE BEBEFITS: I hereby assign, transfer, and set over directly to **Dr. William N. Clearfield D.O.** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic.

I authorize Dr. William N. Clearfield D.O. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Dr. William N. Clearfield D.O.

I authorize Dr. William N. Clearfield D.O. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Government payers, Medicare, other physicians or providers, and any other third-party payers.

RELEASE OF INFORMATION: I hereby authorize the and direct **Dr. William N. Clearfield D.O.**to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event my account is placed in collection status with Summit Collections, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full. Patients inquiring on accounts sent to collections will need to contact Summit Collections directly.

DIVORCED PARENTS of PATIENTS: By signing below, the parent/guardian who signs a minor child into our practice on the day of service accepts full responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent/guardian who signs in that day. Parents/guardians are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable) _____ Date _____

Please print the name of the patient _____

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.

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.

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that William N. Clearfield D.O. has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Patient Name:_____ _____
(Please Print) (Relationship to Patient)

Signature:_____ _____
(Please Sign) (Date)

Do we have your permission to:

Leave a message on your answering machine ☐ Yes ☐ No

Confirm appointments ☐ Yes ☐ No

Speak to household members concerning your medical care and/or billing ☐ Yes ☐ No

_____
Name /Relationship

_____
Name/ Relationship

_____
Name/ Relationship

FOR OFFICE USE ONLY(Please specify)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other:

V1.00

William Clearfield D.O.
9550 S. McCarran Blvd., Suite B
Reno, NV 89523
775-359-1222
drbill@rejuvenatereno.com

Patient Name _____
Reason For Visit_____ **Date:**_____
How Healthy are You Unhealthy 1 2 3 4 5 6 7 Very Healthy_____
Any Hospitlizations? Why?_____
Any Surgery? List_____

Health Issues

Hormone Replacement Heart/Angina/Murmur Eye/Glaucoma Diabetes/Thyroid Dx. Stroke Cancer High Cholesterol Blood Pressure Liver/Hepatitis Migraines Asthma Neurological Issues Heartburn/Colitis/Ulcers Anemia/Blood Issues Sinus Issues Depression/AnxietyPsychiatric Disorders Short of Breath Kidney/Bladder Seizures Arthritis LowBlood Pressure Lung Dissease/Asthma Seasonal Allergies

Any other medical treatment not listed above?_____

Allergies_____
Medications Taking_____
_____

Supplements/Herbs_____
_____
Do you Smoke or Use Tobacco? Never__Daily__On Occasion___Former Smoker__How Many Packs/Day

Use alcohol? Never___Social____Daily____Very Rarely___How many drinks/wk__

Family (Living Y/N Illnesses)
Mother_____**Father**_____
Sisters_____**Brothers**_____
Grandmother(s)_____**Grandfathers**_____

Females
How many times have you been pregnant?_____Date of Last PapSmear_____
Date of Last Mammogram_____

Male/Female:Ever treated for an STD?_____Do you use seat belts Y/N

MALE SYMPTOMS LIST

Androgen Deficiency
____ Low libido
____ Decreased erections
____ Prostate problems
____ Decreased urine flow
____ Increased urinary urge
____ Foggy thinking/Memory loss
____ Decrease mental acuity
____ Arthritis
____ Aches/pain
____ Bone loss
____ Decreased muscle mass
____ Fatigue/Decreased stamina
____ Sleep Disturbances
____ Depressed/Burned out feeling
____ Heart palpitations
____ Thinning skin/Hair loss
____ Irritable

Androgen Excess
____ Acne
____ Oily skin
____ Aggression
____ Irritable
____ Anxious

Estrogen Deficiency
____ Hot flashes
____ Night Sweats
____ Apathy
____ Foggy thinking
____ Bone loss
____ Depression

Estrogen Excess
____ Prostate problems
____ Decreased urine flow
____ Increased urinary frequency
____ Low libido
____ Weight gain in hips/abdomen
____ Nervous/Anxious
____ Irritable
____ Headaches
____ Elevated triglyceride

Progesterone Deficiency
____ Bone loss
____ Prostate problems
____ Decreased urine flow
____ Increased urinary urge
____ Decreased libido
____ Sleep disturbances

Progesterone Excess
____ Sleepiness
____ Mild depression

Cortisol Deficiency
____ Fatigue
____ Sugar craving
____ Allergies
____ Asthma
____ Sinusitis
____ Chemical sensitivity
____ Stress
____ Aches/pains
____ Arthritis
____ Neck/back pain
____ Muscle stiffness
____ Hives/itching
____ Fibromyalgia
____ Low blood pressure

Cortisol Excess
____ Sleep disturbances
____ Bone loss
____ Fatigue
____ Weight gain in waist
____ Loss of muscle mass
____ Thinning skin
____ Anxiety
____ Stress
____ Sugar craving
____ Memory lapse

Thyroid Deficiency
____ Weight gain
____ Fatigue
____ Lack of endurance
____ Dizziness
____ Joint stiffness
____ Depression
____ Anxiety
____ Decreased concentration
____ Muscle weakness
____ Headaches
____ Mood swings
____ Irritability
____ Word mix-ups
____ TSH > 3.0

Thyroid Excess
____ Weight loss/gain
____ Fatigue
____ Shakiness
____ Heat intolerant
____ Restlessness
____ Increased thirst
____ Hair loss
____ Anemia
____ Increased sweating
____ Hives/itching
____ Brittle nails
____ Rapid heartbeat
____ Chest pain
____ Emotional swings/aggression

Name _____

Date _____ Age _____