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 (To be used for appointment reminders) | | | 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** (information used for patient balance statements)

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. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

CHRIS BRATTON, M.D.
CARTHAGE SURGICAL ASSOCIATES
HIGHPOINT HEALTH PARTNERS

## CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. We request timely notification to our practice to enable another patient, waiting for an appointment, to be scheduled. Our goal is to provide the highest quality of care and service to you and other patients.

Please review our policy below:

- **Scheduled Procedures**
  - **48 hours' notice** is required to be timely
  - **$100 fee** for a "No-Show" or Cancellation without timely notice
- **Office Appointment**
  - **24 hours notice.**is required to be timely
  - **$25 fee** for a "No-Show" or Cancellation without timely notice
- Definition of a "No Show": An appointment for which the patient does not attend and has not provided a call to cancel the office appointment or procedure appointment.
- Patients who incur a "No-Show" or untimely Cancellation two (2) or more times in a 12 month period, will be required to obtain a new referral from their Primary Care Physician.
- Insurance does not cover this fee and payment is due at or before the next visit.
- **Patients are responsible for rescheduling the office appointment or procedure.**

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Please ensure to reschedule your appointment.

Questions about cancellation and no show fees should be directed to the Billing Department (615-328-5253). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) _____

Signature of Patient or Patient Representative _____

Date of birth _____

## 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

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

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: _____

# CHRIS BRATTON, M.D.
## CARTHAGE SURGICAL ASSOCIATES
## HIGHPOINT HEALTH PARTNERS

Date: _____

Name: _____ DOB _____

Reason for Appointment : _____

_____

Primary Care Doctor: _____

Office Number : _____

Visit Type: ( Circle one ) New Patient Hospital Follow Up Follow up Visit

**Medical History :** ( Circle all that apply )

Heart Disease Heart Attack Stroke High Blood Pressure High Cholesterol
Diabetes Asthna COPD Seizures Liver Disease Hepatitis C Hepatitis B Acid Reflux
Back Pain Thyroid Problems Fibromyalgia Migraines Anxiety Depression
Kidney Disease Cancer ( type ) _____
Other _____

**Surgical History:** ( If applicable,Please List surgery with year )

| Surgery / Procedure | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Has the Patient ever had any Problems with anesthesia from Previous Surgeries? Yes No**

If Yes please explain : _____

_____

_____

**Allergies:** _____

_____

_____

**Other Allergies:**

**Social History:**

| | Currently Use | | Type / Amount / Frequency | Start Date | Stop date |
|---|---|---|---|---|---|
| Tobacco Use: | Yes | No | | | |
| Alcohol Use | Yes | No | | | |
| Recreational Drug | Yes | No | | | |
| | | | | | |

# CHRIS BRATTON, M.D.
## CARTHAGE SURGICAL ASSOCIATES
## HIGHPOINT HEALTH PARTNERS

**Family History:** ( Please Check all that apply )

| Medical Condition | Mother | Father | Grandparents | Brother | Sister |
|---|---|---|---|---|---|
| Hyper tension | | | | | |
| Heart Disease | | | | | |
| Abnormal Cholesterol | | | | | |
| Diabeties | | | | | |
| Colon Cancer | | | | | |
| Liver Disease | | | | | |
| Cancer ( List Type ) | | | | | |
| Thyroid Problems | | | | | |

**Please Circle :**

Patients Mother : Living or Deceased

Patients Father : Living or Deceased

**Current Medications:**

| Medication Name | Strength | How often you take it |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |
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| | | |
| | | |
| | | |

**Blood Thinners:** Is the Patient on any Blood Thinner Mdeication? ( Plavix, Xarelto, Warfarin, Coumadin , ect.) If Yes please list below.

Medication :

Prescribing Physician:

**Signature:** **Date:**