RANDOLPH PRIMARY CARE REGISTRATION FORM

(Office use only)
Acct#___________

Circle one – Caucasian / Hispanic / African American / other

Methods for communication: Phone____________ Email____

____

Preferred Pharmacy **Location/Address** **Phone Number**

____

Patient's Last Name First Name Middle/Maiden Name Date of Birth Sex

____

Marital Status Social Security Number Driver's License/State Home Phone Number Cell Phone Number

____

Street Address City State Zip

____

Employer Employer Address Employer Phone Number

____/_______________

Spouse's Name Spouse's Date of Birth Spouse's Employer Spouse's Phone cell / work numbers

____

Previous Physician Address Phone Number

Responsible Party and Emergency Information – (a copy of power of attorney or guardianship is required)

____

Person responsible for bills Relationship Address Phone Number

____

Person to Contact In Case Of Emergency Relationship Phone Number

____

Legal Guardian / Healthcare POA Address Phone Number Hospice Agency Phone Number

Insurance Information – (copies of ALL insurance cards are required)

____

Primary Insurance Policy Holder's Name Policy Holder's Social Security Number

____

Secondary Insurance Policy Holder's Name Policy Holder's Social Security Number

____

Tertiary Insurance Policy Holder's Name Policy Holder's Social Security Number

Please read the following Authorizations carefully.

Medical Release: I authorize Randolph Primary Care. PA to pull my pharmacy history for my records. I hereby authorize Randolph Primary Care, PA to receive any PHI necessary for my healthcare needs.

Authorization to Release Information: I authorize Randolph Primary Care, PA to release any information acquired in the course of my examination or treatment to my insurance company, Worker's Compensation carrier or their representatives.

Acceptance of Financial Responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another at fault. Also, if this is a work related injury and the Worker's Compensation carrier denies payment, I understand I am responsible for these charges. I hereby authorize payment directly to Randolph Primary Care, PA of any medical benefits.

Date______________________ Signature (patient/responsible party)____

Randolph Primary Care, PA

350 N. Cox St. Ste. 6
Asheboro, NC 27203
Phone 336/629-2201 Fax 336/629-2205

NOTICE OF PRIVACY PRACTICES

I acknowledge I have received, read and understand Randolph Primary Care, PA's Notice of Privacy Practices. I understand the Notice describes the uses and disclosures of my Protected Health Information (PHI) by Randolph Primary Care, PA and informs me of my rights with respect to my Protected Health Information (PHI).

For more information, please contact Randolph Primary Care, PA's
Privacy officer at 336/629-2201

____

Patient/Representative Signature   Patient/Representative Printed Name   Relationship   Date

____

Reason Patient Cannot Sign

Authorization to Release Medical Information

I authorize Randolph Primary Care, PA to discuss my medical and financial information with the following person(s):

____

Name   Relationship   Contact Method

Authorization to access Electronic Medical Records through the RPC Patient Portal?   Yes_______   No_______

____

Name   Relationship   Contact Method

Authorization to access Electronic Medical Records through the RPC Patient Portal?   Yes_______   No_______

____

Name   Relationship   Contact Method

Authorization to access Electronic Medical Records through the RPC Patient Portal?   Yes_______   No_______

____

Name   Relationship   Contact Method

Authorization to access Electronic Medical Records through the RPC Patient Portal?   Yes_______   No_______

Witness____________________________ Date__________________

Randolph Primary Care, PA

350 N. Cox St. Ste. 6   Asheboro, NC 27203
Phone 336/629-2201
Fax 336/629-2205

Records Release Authorization

Patient Full Name: ______________________________________Previous Name_________________________

Address: ____

Telephone: ____Date of Birth__________________________

I hereby authorize the physician below to release my complete medical records to Randolph Primary Care, PA.
or
I hereby authorize Randolph Primary Care, PA to release my complete medical records to the physician below.
or
I hereby authorize Randolph Primary Care, PA to release____
of my medical record to the physician below.

Physician: ____Phone:_________________________________

Address:____

RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW

I hereby specifically authorize the release of date and information relating to:
HIV/AIDS related testing
Mental Health
Chemical Dependency (Drug/Alcohol)

The authorization will be valid for 365 days from the date it is signed or until ______________, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider in writing, except when the authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my written revocation of this authorization shall not breach my confidentiality rights. Randolph Primary Care, PA cannot condition treatment or payment based on signature of this release. Information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian____

Printed Name of Patient or Legal Guardian____

Relationship to Patient____ Date_________________________

Witness____