IBIS HEALTHCARE

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Moore OBGYN to release any information required to process my claims.

Patient/Guardian signature *Date*

IBIS HEALTHCARE

NOTICE OF PRIVACY POLICY

Dear Patient,

Our office protects the confidentiality of health information by keeping medical records in a highly sophisticated electronic medical record system. We do not reveal personal or medical information unless authorization is given by the patient. Federal and state laws also attempt to ensure the confidentiality of this sensitive information.

The federal government has published regulations designed to protect the privacy of your health information. These regulations (HIPAA) protect health information that is maintained by physicians, hospitals, health care plans and other health industry entities. Every time you are seen by a health care provider, admitted to a hospital, fill a prescription, or send a claim to a health plan, the providers of service will need to abide by these privacy regulations. All health information, including paper records, oral communications, and electronic formats (such as e-mail) are protected by HIPAA.

Our offices take every precaution to safeguard your personal information as outlined above. Our employees are trained to implement all HIPAA privacy rules and regulations. Our computers are equipped to comply with strict HIPAA security measures. All patients have the right to access their medical records. Please feel free to call our privacy officer, Coralee Powell (301-669-1870), with any questions about these rights or how we protect your personal information.

Please sign below to acknowledge that you have received this notice from our office and that you authorize this office to use the insurance, health, and personal information you provide us to facilitate payment of services, coordinate medical care or pursue any outstanding debt for non-payment of services provided. Your signature also acknowledges that a copy of this notice will be kept in your permanent record.

Patient/Guardian signature *Date*

Patient/Guardian Printed Name