HASTINGS INTERNAL MEDICINE ASSOCIATES, PC

REGISTRATION FORM

(Please Print)

Today's date:	Email Address:

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 #.: ( )

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

Occupation:	Employer:	Employer phone #.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Please list additional phone #:

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 ❑ Medicare ❑ BC/BS ❑ Coventry ❑ United ❑ Humana ❑ Aetna ❑ Medicaid ❑ Other

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 Hastings Internal Medicine Associates, PC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Patients Name: _____

Adult Summary Form

Date of Birth: _____

Medical Record #: _____

Primary Care Provider: _____

Drug Allergies/Sensitivities: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	**Date**

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Breast Ca	_____
☐	☐	CAD	_____
☐	☐	Cerebrovas. Dz	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	DM	_____
☐	☐	Fe Storage	_____
☐	☐	Glaucoma	_____
☐	☐	Hyperchol.	_____
☐	☐	HTN	_____
☐	☐	Ovarian CA	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Thyroid Dz	_____

Initial Risk Assessment

	Date
☐ Alcohol/Drug Use	_____
☐ STDs	_____
☐ Domestic Violence	_____
☐ Depression	_____
☐ Osteoporosis	_____
☐ Geriatric Assessment	_____
☐ MMSE	_____
☐ _____	_____

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widow(er)

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____ Date: _____

Hastings Internal Medicine Associates, P.C.
Specialists in adult primary care

2115 N Kansas Ave. Hastings, NE 68901 402-463-2454

BILLING POLICIES

HASTINGS INTERNAL MEDICINE office fees are the usual and customary charges for Internal Medicine physicians in the area. If you are a member of a contracted health plan, our office will file all charges with your insurance company. Patient co-pays are due at the time of service in the amount specified on your current insurance card. All deductible amounts are the responsibility of the patient and account balance statements are sent on a regular basis for mail-in payment or collected during your next visit to the office. Hastings Internal Medicine accepts Visa and MasterCard for payment of services as well as cash, debit cards, and check. Returned checks are subject to a service fee penalty.

If Hastings Internal Medicine is not contracted with your health plan, you are responsible for all charges, a charge statement will be provided to submit to your insurance for reimbursement. Hastings Internal Medicine does accept Medicare assignment and we will bill Medicare. Supplemental insurances that is Medicare Crossover or Medigap will be billed automatically.

Hastings Internal Medicine physicians will work with workers compensation claims if your workers compensation carrier approves your evaluation and care at our office. If your injury or illness is work related, it is your responsibility to inform your employer and file necessary paperwork to activate the workers compensation program. Your workers compensation carrier at your employer may decide where you seek care for your illness and injury and can approve your evaluation and care at our office.

Please inform us of any insurance changes since your last visit and always bring your current insurance cards to your appointment. Each insurance plan has its own unique coverage provisions and not all services rendered may be a benefit or covered by your plan. Payment is expected for non-covered services as determined by your insurance plan. Our office will work to research denied claims, but ultimately the coverage benefits may be unique to your plan or employer or your insurance may have been issued with waivers and you may not be covered for the diagnosis for which you are being treated. Insurance coverage varies by different insurance programs so it is very important that you understand your own health insurance coverage.

Questions on billing, account balances and insurance should be directed to our office personnel. Unpaid balances are due upon receipt unless arrangements have been made with our office manager.

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INSURANCE CLAIMS AUTHORIZATION

I hereby authorize Hastings Internal Medicine to release any information regarding payment or non-payment of claims processing or any information on assigned claims of any treatment or examination provided to me on my behalf.

I also authorize payment of my Medicare/Commercial insurance benefits to Hastings Internal Medicine for all claims files on my behalf. This authorization applies to all services until revoked by me or my representative.

Beneficiary Name _____

Beneficiary and/or Representative Signature _____

Date Signed _____

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ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name (please print) _____

Parent or Authorized Representative (if applicable) _____

Signature _____

Date _____