Regent Medical and Aesthetics Clinic

1209 North Center St Perry Fl 32347 Phone 850-371-5243

Dulcie Yelverton FNP-C

REGISTRATION FORM

(Please Print)

Today's Date:			Your Regular Doctor:
PATIENT INFORMATION			
Patient's Last Name:	First:	Middle:	Marital Status: Single Mar Div Sep Wid
Is this your legal name Yes No	If not, what is legal name?	(Former name):	Birth Date: / Age:
Street address		Social Security #:	Home phone #: ( )
P.O. Box	City:	State:	Zip Code:
Occupation:	Employer:		Employer phone #: ( )
E-mail Address:			
Referred by:	Language Spoken:	Ethnicity: Hispanic Non-Hispanic	
Race: Caucasian Black or African American Asian American Indian or Alaska Native Hawaiian or Other Pacific Islander Other			

INSURANCE INFORMATION				
(Please give your insurance cards and picture ID to the receptionist.)				
Person responsible for bill:	Birth date:	Address (if different):		Home phone #: ( )
Is this person responsible for the bill a patient here? Yes No				
Occupation:	Employer:	Employer address:		Employer phone #: ( )
Is this patient covered by insurance? Yes No				
Name of Primary Insurance:				
Subscriber's name:	Subscriber's S.S. No:	Birth Date:	Policy #:	Group #:
Patient's relationship to subscriber:	Self	Spouse	Child	Other
Name of Secondary Insurance (if applicable):	Subscriber's name:		Policy #:	Group #:
Patient's relationship to subscriber:	Self	Spouse	Child	Other

Regent Medical and Aesthetics Clinic
1209 North Center St Perry, Florida 32347
Phone: 850-371-5243 / Fax: 516-261-7153

Patient Name: ________________________ DOB: _______________

PATIENT MEDICATION LIST
PLEASE LIST **ALL** MEDICATIONS CURRENTLY ON

Medication Name	Dosage	Prescribed by
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________
______________________	____________	_________________

Any known allergies to medications, if so please list:

Patient Signature: ______________________ Date: _______________

HIPAA Authorization for Release of Information Regent Medical and Aesthetics Clinic

I hereby authorize use or disclosure of protected health information about myself

(PATIENT NAME)________________________________(DOB)___________ as described below.

The following people may receive any and all protected health information about myself: _______ No One

Name	Date of Birth	Phone Number	Relationship

Which of the following communication means are appropriate/acceptable for RMAAC to communicate with you:
(Please check all that may apply)

_____ Home Phone – Leave message to return call – no particulars
_____ Home Phone – Leave message with particulars
_____ Work Phone – Leave message to return call – no particulars
_____ Work Phone – Leave message with particulars
_____ Cell Phone # – _______________ Leave message to return call – no particulars _____ Cell Phone # – _______________ Leave message with particulars

In the case of an emergency, or if we are unable to reach you, whom may we contact?
Name: ______________________________ Relationship: ___________________
Phone #: ____

Parent/Guardian Consent

In the event of my absence or availability, I hereby grant RMAAC permission to treat my child/ward ____________________________ for any illness or injury, he/she may encounter. In addition, in the event that I _____________________, the parent am not able to bring my child in for care, I grant __________________________ to bring my child in to be seen **at Regent Medical and Aesthetic Clinic** and treated by RMAAC. I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

I may revoke or withdraw this authorization by notifying in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on ___________________________.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of patient or authorized representative Date

Signature of Witness or Office Staff Date

Regent Medical and Aesthetics Clinic
1209 North Center St Perry Fl 32347
Dulcie Yelverton FNP-C

Date: _____________

PATIENT CONSENT FORM

I hereby grant Regent Medical and Aesthetics Clinic permission to treat myself for any illness or injury I may encounter.

I understand that my medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim, and hereby assign benefits to Regent Medical and Aesthetics Clinic.

Signature: ______________________________

Witness: _______________________________

Please list two names and phone numbers to call in case of an emergency:

PARENT/GUARDIAN CONSENT FORM

In the event of my absence or availability, I hereby grant Regent Medical and Aesthetics Clinic permission to treat my child/ward ______________________________ for any illness or injury he/she may encounter.

I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim; and hereby assign benefits to Regent Medical and Aesthetics Clinic.

Signature: ______________________________

Witness: ________________________________

IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no: ( )
I certify the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Regent Medical and Aesthetics Clinic (Dulcie Yelverton FNP and associates). I understand that I am financially responsible for all charges whether they are paid by my insurance or not. I also authorize the practice or the insurance companies to release any information, including health care data, required to process my claims. ____ Patient/Guardian signature _________________________ Date		

Please list two names and phone numbers to call in case of an emergency:

Regent Medical and Aesthetics Clinic

1209 North Center St
Perry, FL 32347
(850) 371-5243   Fax (516) 261-7153

Authorization to **REQUEST** protected health Information to be released from another Facility:
Receiving From:

Name of Doctor or Facility____

Phone Number:_______________________________ Fax:_______________________________________

Address (if Known):____

Release Medical Records to: Regent Medical and Aesthetics Clinic, 1209 North Center St, Perry, FL 32347
(850) 371-5243   Fax (516)261-7153

For the Purpose of: Changing PCP____ Legal Purpose______ Continuity of care_____ Other _________

Patent Name:____ D.O.B___________

Home Phone:____________________ Cell phone:___________________ Work Phone:_________________

Specific Information to be released: (Check all that apply)
General Records___ Labs/ Test Results____ Progress Notes____ Prenatal Records____

Consultations______ History & Physical____ Immunization______ Other (Specify)______
I specifically consent to release information relating to: (check all that apply)
STD___ HIV/AIDS___ Drug/Alcohol___ Mental Health___

This authorization is valid for **sixty (60) days** from the date of completion of this authorization and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revelation must be provided to Wakulla Urgent Care Medical Records Department. After **sixty (60) days** this document will be shredded if records have not been received.

I understand that I have the right to revoke this authorization in writing at any time. I understand that I must give my written revocation to Wakulla Urgent Care & Diagnostics Center. I understand the revocation will not apply to information already released in response to this authorization.

I understand that the information used or disclosed because of this form may be subject to re-disclosure by the receiving entity and may no longer be protected by the privacy regulations. I also understand that I am under no obligation to sign this authorization and my ability to obtain treatment will not depend in any way on whether I sign this authorization.

Our office protocol for medical records is to have the records sent or faxed to the receiver within 15 days. If the recorders are needed sooner than the minimum time frame, please call medical records at 850-371-5243. We will review the information and decide based on the urgency of need. This is not however a guarantee that we can have them ready by that date. Please note that there is a .15 cent charge per page if we are releasing the records directly to you as a patient.

Signature: ____ Date:___________________

Signature of Witness: __________________________________ Date: ___________________

Office use only   Date Received: _____________________________ Received By: ____________________________

Records are to be: Faxed: ___   Mailed___   Picked up by patient____

Regent Medical & Aesthetics Clinic

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Acknowledgment of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name:______________________ Date of Birth ___/___/___

Signature:__________________________________

Date___________