WESTSIDE
PRIMARY CARE
at Sunrise

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

❑ Dr. ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City _____ State _____ Zip _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM_____/DD _____/YYYY _____ Sex ❑ F-Female ❑ M-Male ❑ Transgender

Race ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Declined

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Language ❑ English ❑ Spanish ❑ Indian ❑ Japanese ❑ Chinese ❑ Korean ❑ French ❑ German ❑ Russian ❑ Other _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number _____-_____-_____ Employer Name _____

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

Emergency Contact Last Name _____ First Name_____

Phone Number _____ Do you have a living will? ❑ Yes ❑ No

Emergency Contact Relationship to Patient _____ ❑ Guardian

Address Line 1 _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self **Check here if information is same as patient ❑**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____ /DD _____/YYYY_____

Social Security Number _____-_____-_____ Telephone _____

E-Mail Address _____ Sex ❑ F - Female ❑ M - Male

Address Line 1 _____

City _____ State _____ Zip _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number (_____) _____

Name of Insured _____ Patient Relationship to insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount_____

Effective Date _____ Termination Date _____ Date of Birth MM _____ /DD _____/YYYY_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number (_____) _____

Name of Insured _____ Patient Relationship to insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount_____

Effective Date _____ Termination Date _____ Date of Birth MM _____ /DD _____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

Consent for Treatment and Payment Agreement

I hereby authorize **Westside Primary Care @ Sunrise** to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Payment includes but is not limited to: the authorization of payment directly to **Westside Primary Care @ Sunrise** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Westside Primary Care @ Sunrise, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

I assign the benefits payable for services to Westside Primary Care @ Sunrise

I request this authorization also apply to all other insurance.

Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

Patient Initial: _____

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
_____	Y N	Y N
_____	Y N	Y N
_____	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I acknowledge that I have been given Westside Primary Care @ Sunrise Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature_____

Date_____

Financial Policy

WESTSIDE PRIMARY CARE at Sunrise

(please read and sign)

As your physician(s), we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

You will be required at each visit to present the office with your insurance card. You are also expected to notify us of any changes in name, address, phone or insurance information. Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments and any deductible required at the time of visit.

Unless arrangements have been made in advance, **co-payments, co-insurance and any outstanding balances are expected at the time of service.** Patients may be financially responsible for payment of all services, even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections or legal procedures.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Patient accounts not paid promptly are subject to third party collections or legal procedures.

We are participating Medicare providers and we will file Medicare for you. We request that any service routinely not covered by Medicare (i.e., Preventative Exams) be paid at the time of service. We request payment for 20% of allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.

We also do not accept Letters Of Protection on an auto liability case. We do not participate in the treatment of illnesses in Worker's Compensation claims.

Any check returned from the bank will result in an additional ($20) charge that will appear on your account.

We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

If at any time you have any unanswered questions or concerns, please feel free to address those issues directly with our Office Manager.

Patient Date

Witness Date

Patient Health History Questionnaire

Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT

Reason for your visit to our office? _____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	Start Date

ALLERGIES

Do you have any allergies to the following? **(Please check all that apply and explain below)**

Medications_____

Iodine_____

Shellfish/Seafood_____

Foods_____

Other_____

_____

FAMILY HISTORY

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Mother				
Father				
Sister				
Sister/Brother				
Sister/Brother				
Son/Daughter				
Son/Daughter				

SOCIAL HISTORY

Do you smoke?

- Yes, I have smoked _____ packs of cigarettes per day for _____ years.
- No, I have never smoked.
- No, I quit _____ years/months ago. At the time I smoked _____ packs a day for _____ years.
- Yes, I smoke a cigar or pipe.

Do you use recreational drugs? ( ) Yes ( ) No **(If yes please list below)**

_____

Do you drink Alcohol?

- Yes, ( ) Daily ( ) 1 or more times a week ( ) 1 or more times a month.
- No, never or rarely
- No, but I used to

MEDICAL HISTORY

Do you currently or have you ever had problems with any of the following
(PLEASE CIRCLE YES or NO)

Constitutional		
Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Eyes		
Do you wear glasses	Yes	No
Infections/Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Ear, Nose, Throat and Mouth		
Wear Hearing Aids	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Balance Disturbance	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular

Chest Pain or Angina	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
Swelling in feet or hands	Yes	No
Leg Pain while walking	Yes	No

Respiratory

Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Bloody Sputum	Yes	No

Gastrointestinal

Indigestion	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

Genitourinary

Urinary Tract Infections (UTI)	Yes	No
Painful Urination	Yes	No
Blood in Urine	Yes	No
Difficulty Starting/Stopping Stream	Yes	No
Incontinence	Yes	No
Prostate Cancer (Males)	Yes	No
Endometriosis (Females)	Yes	No
Uterine or Cervical Cancer (Females)	Yes	No

Musculoskeletal

Broken Bones	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No

Integumentary

Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Tenderness or Swelling	Yes	No
Nipple Discharge	Yes	No

Neurological

Fainting Spells or Blackouts	Yes	No
Seizures	Yes	No
Problems with Memory	Yes	No
Disorientation	Yes	No
Difficulty with Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Poor Coordination in Arms and or Legs	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Increase in Appetite	Yes	No
Excessive Thirst	Yes	No
Hormone Problems	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/Lymph Nodes	Yes	No
Blood Transfusions	Yes	No

If yes, when? _____

PAST SURGICAL HISTORY & PREVIOUS HOSPITALIZATIONS

Please list any surgeries and/or hospitalizations. Please include date and complications if any.

_____

_____

_____

Please list any major Illnesses and or injuries. _____

_____

_____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient's Signature: _____ Date: _____

I HAVE READ AND REVIEWED THE ABOVE INFORMATION

MA's Signature: _____ Date:_____

Westside Primary Care Sunrise
Patient HIPAA Acknowledgment and Consent Form

Patient Name**:** _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- 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. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____. 000 - 0000.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____
Name: _____ Date: _____

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date _____