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Patient Registration Form

Date: .....

First Name .....Middle.....Last Name.....Sex: M F

Preferred name: "....." Preferred Language.....

Date of Birth ....Birth Place ..... Ethnicity.....

Street Address..... Town .....ZIP Code.....

Home # ..... Cell# .....Work# .....

E-mail ID.....

Social Security #..... Occupation.....

Employer Name/Address.....

Pharmacy Name .....Phone#.....

Family Marital Status: Single Married Divorced Widow Significant other (Name) .....

Spouse's Name .....Date of Birth .... Number of Children: ...

Spouse's Employer Name and Phone# .....

Emergency Contact Name: ..... Ph. #.....

Insurance: Name of the Insured person.....DOB .....

Name of Insurance ..... ID# .....

How did you know about our practice?

Family/Friends Advertiser newspaper Internet Insurance

Other (specify) .....

What did you like about our practice? ....

Our Office Policies

- All refills will be given at the time off an office visit only. Medications will not be called between office visits.
- Missing an appointment without notice (No-show) or cancellation with less than 24-hour notice may incur surcharge up to $50. Multiple No-shows will lead to discharge from the practice.
- Co-pay not paid at the time of service may incur a surcharge of $5.
- Balances on accounts not paid in a timely manner may be turned over to a collection agency. There will be a charge for all costs associated with this action including the collection fees.
- It is the patient's responsibility to call their insurance company to make sure our physician is in their network to avoid any additional charges or fees.

Medical Information

Chief Complaint.....

Medications/Dosage

Present.....

.....

Past year.....

.....

Are you Allergic to or intolerant of any drugs? If yes, please list the drugs and your reaction

.....

Operations/dates.....

.....

Other Major Illnesses and Hospitalizations

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.....

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Do you smoke? .....Packs/Day.....Did you smoke? ..... Date stopped? .....

How often do you have a drink (Beer, Wine, Liquor?) .....

Have you ever had any problems related to alcohol? .....

If there is any history of following in either yourself or immediate family, please note below:

Alcoholism.....High Cholesterol.....

Arthritis ....Kidney disease.....

Asthma.....Mental illness.....

Cancer..... Osteoporosis.....

Diabetes.....Stroke.....

Heart disease..... Tuberculosis.....

High blood pressure.....

Privacy

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Send your medical information to your personal E-mail?	Yes	No
Discuss your medical condition with a member of your household?	Yes	No

If yes, Name: ..... Relationship: .....

We encourage you to register for secure e-mail through our website: doctorpadma.com to receive our messages, test reports and more.

Consent to treat and assignment of benefits/ authorization to release information:

I consent to treatment necessary for the care of the patient name on this document. I authorized Columbia Internal Medicine LLC to submit claims to my insurance carrier and release any information needed for the processing of claims related to medical services rendered. I allow for release of my personal health information according to HIPPA law for the treatment, payment and operations. I authorized assignment of benefits for physician and lab services to Columbia Internal Medicine LLC. A copy of the signature is as valid as the original. I understand that I am financially responsible for any services not covered by my insurance carriers.

The information I have provided on this registration form is true to the best of my knowledge. I acknowledge that I have received, read and understand the financial and office policies of Columbia Internal Medicine.

Patient (Please print) .....

Signature.....Date.....

Parent/Guardian (Please print).....

Signature.....Date.....

Additions/ Changes/ Comments (If any)

The Patient -Centered Medical Home

The Provider – Patient Agreement

Synopsis

The goal of Columbia Internal Medicine is to provide patient centered care to all of its patients. Patient centered care is a means for the provider, patient and families work together with the goal of providing quality healthcare to the patient. This will be achieved through patient and family interaction whereby the needs and preferences of the patient are communicated to Columbia Internal Medicine. Columbia Internal Medicine in turn will listen to these needs and then focus on their education and training to ensure better healthcare results.

Objectives

Columbia Internal Medicine and the patient will achieve this patient centered care based on the following mutually agreed upon terms:

Columbia Internal Medicine will provide quality healthcare to the best of their ability and knowledge, in a safe environment.

Patients and their families have the ability to ask questions and voice concerns through an open channel of communication with our providers.

The patient/parent is honest in the history of symptoms. Columbia Internal Medicine's provider is open and honest in relating the diagnosis and related treatment. It is important for the patient/parent to disclose all the symptoms or medical problems at the time of treatment.

The patient/parent is compliant in following agreed upon treatment plans. Columbia Internal Medicine will provide clear and understandable instructions.

Columbia Internal Medicine will provide patients with sufficient time during their office visit to ensure the medical problems are s understood and the treatment protocol is thoroughly explained. Both the patient/parent and provider shall respect one another's time.

The patient/parent will pay for their share of the provider services rendered not covered by their insurance at the time of the office visit. It is the patient/parent responsibility to know their insurance benefits.

Columbia Internal Medicine provides reasonable office hours and has instructions for after hour emergencies through their office telephone number, which includes access to a physician by phone 24/7.

Columbia Internal Medicine offers same day appointments for acute care and allots appropriate time frames for follow up, preventative care and disease management appointments.

• Columbia Internal Medicine may refer patients to a specialist or suggest certain tests/procedures that are not done in the office. Instructions will be provided for these instances. It is the patient/parent responsibility to find out if the specialist is covered by their insurance.

• Columbia Internal Medicine is not responsible for costs incurred by the patient for specialty care or tests/procedures recommended by our providers.

• Columbia Internal Medicine will facilitate the referral process. However, it is the responsibility of the patient/parent to follow up with the referral and understand the insurance coverage for the specific referral.

• Columbia Internal Medicine will provide results of lab/x-ray tests by calling the patient/parent. The patient/parent should call the office if not notified about test results in an appropriate time frame.

• The patient/parent shall do their best to participate in healthy habits and lifestyles.

• Columbia Internal Medicine may provide educational resources. The patient/parent utilizes these resources and asks questions if needed.

• The patient/parent will keep their appointments. Otherwise a missed appointment fee will be applied.