DURHAM FAMILY MEDICINE

# Patient Registration Form

Social Security #_____Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____
Street

_____
City, State, Zip Code

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

**Circle One** **Sex:** Male Female **Marital Status:** Single Married Divorced Other

Patient's Employer:_____

Employer's Address:_____
Street, City, State, Zip

Employer's Phone #:_____

*How did you hear about us?* (circle one) friend, newspaper, yellow pages, dentist/doctor

Other: _____

**BILLING AND INSURANCE INFORMATION**

Name of Insurance Company:_____

Membership #:_____Group #:_____

Name of Policy Holder:_____ Date of Birth (policy holder):_____

SS# (policy holder):_____

Employer of Policy Holder:_____

Secondary Insurance:_____

Membership #:_____Group #:_____

Name of Policy Holder:_____ Date of Birth (policy holder):_____

**FAMILY MEMBERS**

| | Name | Sex | Date of Birth | Relationship |
|---|---|---|---|---|
| Female Head of Household | | | | |
| Male Head of Household | | | | |
| Child/Dependent | | | | |
| Child/Dependent | | | | |
| Child/Dependent | | | | |

Signature of Person Completing This Form Date

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# Notice of Privacy Policies

As requested by the Federal privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), effective April 14, 2003.

This summary briefly describes how **Durham Family Medicine** may use and disclose your Protected Health Information (PHI) to carry out our treatment, payment activities, healthcare operations and for the purposes that are permitted or required by law. It also summarizes your rights to access and control your PHI.

## Our Responsibilities:

We are required by law to maintain the privacy of your PHI. In accordance with the HIPPA Privacy Regulations, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We are most likely to use and/or disclose your PHI for these functions.

Additionally, we may use or disclose your PHI as permitted and required by law. For example, we may use or disclose your PHI for public health activities, legal proceedings, or enforcement purposes.

## Your Rights:

You have the following rights regarding your PHI:

- You have the right to request that Durham Family Medicine (DFM) communicate with you in an alternative manner or at an alternative location.
- You have the right to request that DFM restrict the PHI we use or disclose about you for treatment, payment or health care operations.
- You have the right to inspect and copy your PHI that is contained in a designated record set.
- You have the right to request an amendment if you believe that your PHI is incorrect or incomplete.
- You have the right to request an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment or health care operations.
- You have the right to receive a paper copy of the DFM HIPPA Notice of Privacy Practices.
- You have the right to authorize disclosures of your PHI for reasons other than treatment, payment, or health care operations.

## Complaints:

You may complain to us if you believe we have violated your privacy rights. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

DURHAM FAMILY MEDICINE

I acknowledge that I was given a copy of the HIPPA Notice of Privacy Policies from Durham Family Medicine. It explains how health information about me may be used.

_____

Patient's name

_____

Signature of Patient or Responsible Party Date

## Contact Information:

## May we call you at?

**Home** **YES** **NO**

May we leave a message on your home answering machine? **YES** **NO**

**Work** **YES** **NO** **N/A**

May we leave a message at work ? **YES** **NO**

**Cell Phone** **YES** **NO** **N/A**

May we leave a message on your cell phone? **YES** **NO**

If we cannot reach you, is there any person(s) who has your permission to receive information and answer questions on your behalf? If so, please list:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

_____

Signature of Patient or Responsible Party Date

*Note: If you have joint custody of your child, both parents are entitled to have access to the child's records.