Please fill out and mail back to:
Pittsford Family Medicine
115 Sully's Trail Suite 4
Pittsford, NY 14534

PITTSFORD FAMILY MEDICINE
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

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: ( )	Cell Phone: ( )

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

Occupation:	Employer:	Employer phone no.: ( )

Email:

Race: ❑White ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific ❑ Hispanic ❑Black or African American ❑ Other: _____ ❑ Decline

Ethnicity: ❑Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline

Language: ❑English ❑ Spanish ❑ Russian ❑ French ❑ Indian ❑ Other

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.: ( )

Please indicate primary insurance ❑ Cigna ❑ Aetna ❑ BCBS ❑ Child Health Plus ❑ Anthem ❑ United Healthcare ❑ Family Health Plus ❑ MVP ❑ UMR ❑ Other

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	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 Pittsford Family medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

I, the undersigned, realize that I am financially responsible for all services rendered by Pittsford Family Medicine. Full payment in the form of cash, check, or credit card is expected at the time of service unless other arrangements are made before the day of the appointment. Insurance required co-pays are due the day of service to avoid a late fee.

For those insurance plans for which Pittsford Family Medicine accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance carrier.

All returned checks are subject to a returned check fee. Twenty-four hours notice is required for all appointments you are unable to keep. If proper notice is not given, a broken appointment charge may be applied to your account. Any services that generate a bill are due within 30 days or a late fee may be applied.

It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency and/or attorney for recovery, that I will be fully responsible for any costs, including, but not limited to attorney's fees.

_____ _____

Signature of Patient/ Responsible Party Date

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Pittsford Family Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Pittsford Family Medicine** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Pittsford Family Medicine** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Pittsford Family Medicine** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Pittsford Family Medicine**.

With this consent, **Pittsford Family Medicine** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Pittsford Family Medicine** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Pittsford Family Medicine** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Pittsford Family Medicine** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Pittsford Family Medicine** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Pittsford Family Medicine]** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable
