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BLUE RIDGE CHRONIC PAIN CENTER
Guiding Your Journey to Wellness

Patient Registration Form

PATIENT INFORMATION **Referring Physician** _____

Patient Name: Last _____ First _____ Middle _____

Address _____ City _____ State _____ ZIP _____

Sex: (Please Circle) Male/Female Title: (Please Circle) Dr. Mr. Mrs. Ms.

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth date ___ ___ - ___ ___ - ___ ___ Home Phone (___) _____

Work Phone (___) _____ Marital Status _____

Email Address: _____

Employer/Address _____ City _____ State _____

Emergency Contact _____ Phone Number (___) _____

RESPONSIBLE PARTY

Guarantor's Name _____ Phone Number (___) _____

Address _____ City _____ State _____ ZIP _____
(If different from above)
Patient Relation to Guarantor _____ Guarantor Employer _____

Employer Address: City _____ State _____ ZIP _____

Guarantor SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Guarantor Birth date _____

PRIMARY
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

SECONDARY

Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

I hereby authorize Blue Ridge Chronic Pain to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Blue Ridge Chronic Pain benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

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

Patient's signature (or responsible party) _____ Date _____

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No show and late cancellation policy Effective August 1, 2017

Please be advised, if you do not show up for your appointment, or you cancel without proper notice (I.E., less than 24 hours in advance), your account WILL automatically be assessed a fee of $50.00. The fee will need to be paid on or before your next visit with our office.
If you are ill, please call our office as soon as you are able. We will waive the cancellation fee.

Thank you in advance for your consideration.

Patient Signature:_____ Date:_____

Allergy

_____
_____
_____

Medication

_____
_____
_____
_____
_____
_____
_____
_____

Reason for Visit

_____
_____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, do hereby authorize and request _____
(Print Full Name) (Name of Health Care Entity)

to release and disclose protected health information of: _____
(Patient Name)

Patient / Requestor Address

Patient's Address: _____ Date of Birth: _____

_____ Social Security #: _____

_____ Phone #: _____

To:

Name: _____

Address: _____

_____

_____

Please specify the Protected Health Information to be released by marking the following:
Are you requesting psychotherapy notes? ☐ Yes, then you may only request psychotherapy notes on this authorization. You must submit a separate authorization for other items. ☐ No, then you may check as many items below as you need.

○ Discharge Summary ○ Complete Record ○ Other (Specify)	○ History & Physical ○ Radiology Reports /Films ○ Lab Reports	○ Operative Path Report ○ Emergency / Outpatient EKG / ○ EEG/ECHO/Stress ○ Treatment Date(s) Requested

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing, HIV results or AIDS information. _____ (initial).
The Purpose of this disclosure is for: _____ Medical Care, _____ Changing PCP/Family Physician, _____ Changing Specialists, _____ Insurance Processing, _____ Legal, _____ at the request of Individual, _____ Other (Specify).

I understand that:

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential Health records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is a potential that information disclosed may be redisclosed by the recipient and no longer protected by law. A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original health records.

- This Authorization will automatically expire one year after the day below **OR** on _____.
- **A fee may apply to copies of PHI that I request, whether received by me or by another recipient I authorize. I may ask for a cost estimation / invoice prior to the information being copied.**

SIGNATURE: _____ DATE: _____
(Signature of Patient / Legally Authorized Representative) (Specify Date)

_____ _____
(Relationship to Patient / Description of Authority to Act) (Address and Telephone Number of Legally Authorized Representative)

_____ DATE: _____
(Signature of Witness)

HIM Employee Verified Identification of Requestor _____ (initial)

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

Blue Ridge Chronic Pain

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Information). I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name	Relationship, if any
_____	_____
_____	_____
_____	_____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or know the status of my health.

4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time be sending a letter addressed to the Privacy Office to any office where I am treated by Provider.

5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this consent.

6. Re-disclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

If a representative signs, state the Representative's Authority:

_____