Harbor View
MEDICAL SERVICES, PC

Today's date:_____ Scheduled to see Dr.:_____

DEMOGRAPHIC INFORMATION

Patient's Legal Name: _____ _____ _____
Last First MI

Sex (circle one): ❑ M ❑F Date of Birth:_____ Social Security Number:_____

Address:_____ City:_____ State:____ Zip Code:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email:_____ Contact Preference:_____

Primary Language: _____ Ethnic Group: Hispanic or Latino Not Hispanic or Latino

Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑Multiracial

❑Native Hawaiian or Other Pacific Islander ❑Another race ❑White

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced

Emergency Contact: _____
Name Relationship Phone Number (s)

INSURANCE INFORMATION

Primary Insurance: _____ Relationship to the policyholder:_____

Policy Number:_____ Group Number:_____

Claims Address:_____ Referral Required: ❑Yes ❑No

Policyholder's Name:_____ Policyholder's DOB:_____

Policyholder's Social Security Number: _____ Address (if different): _____

Policyholder's Employer:_____ Phone: _____

Secondary Insurance: _____ Relationship to the policyholder:_____

Policy Number: _____ Group Number: _____

Claims Address: _____ Referral Required: ❑Yes ❑No

Policyholder's Name:_____ Policyholder's DOB:_____

Policyholder's Social Security Number: _____ Address (if different): _____

Policyholder's Employer:_____ Phone: _____

Harbor View
MEDICAL SERVICES, PC

ADDITIONAL PATIENT INFORMATION

Referring Provider:_____

Primary Care Provider:_____

Ordering Provider:_____

Nephrologist:_____

Cardiologist:_____

Local Pharmacy: _____
Address: _____ City _____ Zip: _____
Phone:_____ Fax:_____

Mail Order Pharmacy: _____
Address: _____ City _____ Zip: _____
Phone:_____ Fax:_____

Allergies or ***reactions*** to medications: ❑No ❑Yes If yes, list allergy & reaction: _____

_____

_____

_____

Current Medications ❑**No Meds** ❑**List Provided** If no list provided, please list: _____

_____

_____

_____

Smoking Status: ❑ Current Smoker—Specify frequency_____ ❑**Former Smoker** ❑ **Never Smoked**

Harbor View
MEDICAL SERVICES, PC

Health Insurance Portability & Accountability Act (HIPAA)

Patient's Name: _____ **Date:**_____

This form contains how your Protected Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

1. I understand and agree to allow Harbor View Medical Services, PC to use my PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. I have the right to my exam and to obtain a copy of my own health records at any time and request corrections. I may request the disclosures that have been made and submit in writing any further restrictions on the use of my PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. I may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Harbor View Medical Services, PC to assure that your records are not readily available to those who do not need them.
6. I understand that incidental disclosures of my PHI may be made. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
7. I have the right to file a formal complaint with the privacy official about any possible violations of these policies and procedures.
8. If I refuse to sign this consent for the purpose of treatment, payment and health care operations, the office has the right to refuse care.

Please answer the following questions indicating any restrictions

9. I agree that the office has the right to call my home or place of employment regarding appointment and/or insurance issues.

   ○ Yes ○ No Restrictions: _____

10. I give permission to the office to call me and/or leave messages for me on an answering machine/voice mail.

    ○ Yes ○ No Restrictions: _____

11. Other than myself, I authorize the physician(s)/practitioner(s) of Harbor View Medical Services, PD to share/discuss my medical information with:

Name:	Relationship	Phone
Name:	Relationship	Phone

I acknowledge that I have read or have had read to me the above information. I have also had the opportunity to ask questions about it and understand that **I** may receive a copy of this at my request. By signing below **I** agree to the above mentioned stipulations. I understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signed: _____ Date: _____

Signature of Patient or Legal Representative

If signed by legal representative, please indicate the relationship: _____

Harbor View
MEDICAL SERVICES, PC

Assignment of Benefits

Patient's Name: _____ **Date:** _____

1. I authorize, assign and direct my insurance carrier to pay directly to Harbor View Medical Services, PC, dba Primary Care Associates for services rendered to me, now or hereafter, which are payable under my insurance contract or contractual agreement.

2. I agree that in the event that I receive checks, drafts or other payment subject to this agreement, I will act as fiduciary agent to the office. The office agrees to apply any proceeds to my debt for services rendered.

3. I fully understand and agree that insurance policies are an arrangement between the insurance carrier and me. I will be responsible for expenses not paid by the insurance carrier. I also understand that I am responsible for any referrals required by my insurance carrier.

4. **I UNDERSTAND THAT THE PROVIDER IS LEGALLY OBLIGATED TO COLLECT ALL COPAYS, DEDUCTIBLES &/OR COINSURANCE DEEMED TO BE PATIENT/INSURED RESPONSIBILITY BY THE INSURANCE COMPANY.** (NOTE: Some insurance carriers require an additional copay/coinsurance for tests performed during an office visit. If so, you will be billed for this after the claim has been processed and we have been so instructed by the insurance carrier of your additional responsibility.)

5. I understand that **I** must provide all information required for my Worker's Compensation/No Fault insurance or I will be responsible for the expenses incurred.❑ **Not Applicable** ❑ **Information provided**

6. I understand that, if necessary, the office may employ collection counsel and/or an attorney on my bill, I will be responsible for any said collection and/or attorney fees.

I acknowledge that I have read or have had read to me the above information. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below I agree to the above mentioned statements.

Signed: _____ Date: _____

Signature of Patient or Legal Representative

If signed by legal representative, please indicate the relationship: _____