

NEW PATIENT REGISTRATION*Please print clearly and use your full legal name (no nicknames).***PATIENT INFORMATION**

Last Name:		First Name:		M.I.:	
Date of Birth:	Age:	Sex:	Marital Status:	Driver's License #:	
Street Address:					
City:		State:		Zip Code:	
Cell Phone:			Home/Work Phone:		
Email:			Preferred Language:		
Employer Name & Address:					

GUARANTOR INFORMATION *(complete only if different from patient)*

Last Name:		First Name:		M.I.:	
Date of Birth:	Relationship to Patient:		Phone:		
Employer Name:			Employer Phone:		

INSURANCE INFORMATION *(or provide a copy of all insurance cards)***Primary Insurance**

Insurance Company:		Claims Address:			
Phone:	Member ID #:		Group #:		
Subscriber Name:		Subscriber DOB:		Relationship to Patient:	

Secondary Insurance

Insurance Company:		Member ID #:		Group #:	
Subscriber Name:		Subscriber DOB:		Relationship to Patient:	

MEDICARE BENEFICIARY NOTICE *(Medicare patients only)*

Medicare Beneficiary Identifier (MBI):	Part A Effective Date:	Part B Effective Date:
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Authorization & assignment of benefits. I request that payment of authorized Medicare benefits be made on my behalf to CareFirst 360 for services furnished to me. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits payable for related services.

Advance Beneficiary Notice (ABN). Medicare does not pay for all services, including those it considers not medically necessary or performed more often than allowed. If we expect Medicare may deny payment for a service, you will be asked to sign an ABN before the service is provided. If you choose to receive the service, you may be personally responsible for payment.

Signature of Medicare Beneficiary / Representative:	Date:
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Notice of Patient Rights and Responsibilities: available on our website for review, or ask the front desk for a printed copy.

PATIENT CONSENTS & ACKNOWLEDGEMENTS

Patient Name: _____

Date of Birth: _____

1. Medical Care and Treatment. I voluntarily consent to examination, diagnosis, treatment and other medical services – including x-rays, laboratory procedures, tests and medications – recommended by the physicians of CareFirst 360, their assistants, nurses or designees. I understand the practice of medicine is not an exact science and that no guarantees have been made to me about results.

2. Privacy Notice and Use of Health Information. I understand CareFirst 360 creates and maintains records of my health history, symptoms, exam and test results, diagnoses and treatment plans, and may use or disclose this information for treatment, payment and health care operations (e.g., planning my care, communicating with other providers, billing, and verification by my insurer). I acknowledge that I have been offered the CareFirst 360 Notice of Privacy Practices, may review it before signing, and will receive any revised notice. I may request restrictions on use or disclosure (CareFirst 360 is not required to agree, but is bound by any it accepts) and may revoke this consent in writing except where action has already been taken.

Requested restrictions (optional): _____Office use: ☐ Restrictions accepted ☐ Restrictions denied

3. Electronic Health Record and Telemedicine. CareFirst 360 uses an electronic health record that links my clinical record with scheduling, registration and billing, with privacy and security safeguards in place; as with any record system, some risk of loss, inadvertent disclosure or error remains. I consent to the use of telemedicine in my diagnosis and treatment and to the electronic transfer of my health information to other practitioners and entities involved in my treatment, payment or health care operations.

4. Electronic Prescriptions. I consent to electronic prescribing, including retrieval of my prescription eligibility, benefit, formulary and medication history, and real-time delivery of prescriptions to retail and mail-order pharmacies.

5. Patient Portal. I may use the free, secure patient portal to view my chart, pay bills, send secure messages, and request appointments and non-controlled medication refills. CareFirst 360 may suspend or terminate portal access at any time.

6. Communication & Participation Preferences

These are our standard practices. Check “Opt out” only for any you do NOT agree to.	Opt out
Leave test results and medical information on my voicemail / answering machine.	☐
If I cannot be reached, leave a message with the person who answers asking me to call back.	☐
Send appointment reminders by phone, text, e-mail or reminder card.	☐
Allow my records to be reviewed by research staff to support clinical research and identify possible study participants.	☐
Allow supervised nursing/medical students, residents and fellows to observe or assist in my care.	☐
Allow students in teaching programs to accompany my physician on hospital and dialysis rounds.	☐

People who MAY receive my medical information and test results (name, relationship, phone): _____

By signing below, I confirm I have read and agree to items 1–6 above and acknowledge receipt of the Notice of Privacy Practices. These consents continue throughout my care and any or all may be revoked at any time by written request.

Signature of Patient / Legal Representative: _____

Date: _____

Printed Name: _____

If representative: relationship / authority: _____

Personal Representative / Guardian name (if any): _____

Phone: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

RELEASE FROM

I request and authorize the following provider/facility to release the medical records of the above-named patient:

Provider / Facility Name: _____ Phone: _____

Address, City, State, Zip: _____ Fax: _____

RELEASE TO

Name of Recipient: _____

Address: _____

City & State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Reason for Release: _____

INFORMATION TO BE RELEASED *(check one)*☐ Healthcare information relating to the following treatment, condition or dates of treatment:

Condition / dates: _____

Please send: face sheet, H&P, consultation notes, discharge summary, laboratory results and radiology reports.

☐ All healthcare information, INCLUDING information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.☐ All healthcare information, EXCLUDING information relating to HIV/AIDS testing, sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use.**I authorize the release of the records described above. I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.**

Signature of Patient / Legal Representative: _____ Date: _____

Printed Name: _____ If representative: relationship / authority: _____