Onslow Medical Specialties Clinic
123 Pompano Place Suite 100
Jacksonville, NC 28546
Phone: 910-455-9398; Fax: 910- 455-5407

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Per insurance guidelines they are requesting patient race and ethnicity. The information requesting on this form is for data collecting purposes only and will not be used for any other reasons. Please fill in the blanks below the line.

Patient Name Last, First, Middle)	Today's Date	Date of Birth	Sex	Age
Patient's Social Security Number	Marital Status		Language	
Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Other/Unknown				
Race □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian □ Other □ Other Pacific Islander □ White				
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number	Cell Telephone Number		Work Telephone Number	
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer			
Primary Physician's Name			Pharmacy	
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name	Relationship			
Address	City	State	Zip	
Home Telephone	Work Telephone	Cellular Phone	Other	
Nearest Relative (not living with your)				
Home Telephone	Work Telephone			
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name	Telephone			
Address	City	State	Zip	
Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:	Group No:	Authorization No:		
Secondary Insurance	Claim Address	Insurance ID./Group No.	Authorization No.	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		

ONSLOW MEDICAL SPECIALTIES CLINIC

Eusebio Desuyo, MD, MBA, MPH

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CLINIC POLICIES

Please read the following clinic policies.

Cancellation of Appointment: In fairness to other patients and the physician, we require at least 24 hours' notice to cancel appointments. If you fail to do so, it will be considered a NO SHOW or MISSED appointment unless you have a reasonable valid reason.

No Show or Missed Appointment: There will be a charge of $50 for every missed appointment. If you missed your appointment at least twice without paying your dues, we may not be able to schedule you for an appointment until you pay your dues.

Returned Checks: There will be a charge of $25 for each returned check.

Basic Financial Policy: Pay for service is due in full at the time service is provided in our office.

Patients with Insurance: We will bill most insurance/Medicare/Medicaid for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. **Co-payments and deductibles** are due at the time of service upon check-in. If an insurance carrier has not paid within 45 days of billing, professional fees are due and payable in full from you. **Co-insurance** is also due at the time of visit.

Non-covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Account Balance: If your account balance is $500 or more 60 days after the date of service, please make some kind of payment arrangements with us. Otherwise, we may not be able to schedule you for any appointment until we know that you are going to try to make payments in good faith. Furthermore, we may submit your account balance to a collection agency and dismiss you from the practice. To avoid this you can discuss your account statement with us.

Acknowledgement and Assignment of Insurance Benefits:

I have read, understood and agreed with the above clinic policies. I request that payment of authorized Medicare or commercial insurance benefits be made to or on my behalf to Onslow Medical Specialties Clinic, for any services furnished to me by one of its providers. I authorize any holder of information about me to Centers for Medicare/ Medicaid Services and its agents any information needed to determine these benefits or the benefits payable related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare or commercial insurance carrier. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Name/Representative/Guarantor: _____

Signature:_____ Date:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by means such as sending correspondence to an address other than home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:
__ Leave message with detailed information
__ Leave message with call back number only
__ Fax to this number_____

Written Communications:
__ Mail home address
__ Mail work/office

Work Telephone:
__Leave message with detailed information
__Leave message with call back number only

Other:
_____
_____

_____ _____
Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. **Uses and Disclosures for Onslow Medical Specialties Clinic may be permitted without prior consent in an emergency.**

Healthcare entities must keep records of PHI disclosures. Information provided below will constitute this record. Please list who we may disclose information to such as appointment times, lab results or medication information.

Disclose information to	Relation to Patient	Address or Phone #	Disclose this information

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PATIENT ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA).** I understand that this information can and will be used to:

□ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

□ Obtain payment from third-party payers for my health care services

□ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of this facility's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that this facility has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name or representative:_____

Relationship to Patient: _____

Signature: _____

Date: _____

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PHOTO AUTHORIZATION FORM

I authorize **_Onslow Medical Specialties Clinic___** to use and disclose my protected health information (PHI) listed below.

_**X**___Take my photograph

Entity or person(s) authorized to receive this information:

_**X**____Practice staff members only

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

_**X**____Released from care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (123 Pompano Place Suite 100, Jacksonville, NC 28546). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Personal Representative's Authority

(Provide a copy of this form to the patient.)

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(910) 455-9398 (ph) (910) 455-5407 (fax)

Authorization for Disclosure of Health Information

1) **Patient Information**: _____
Name of Patient/ Previous Name

_____
Address City/State/Zip

_____/_____/_____ (_____)_____-_____ _____-_____-_____
Date of Birth Telephone Number Social Security #

2) **Persons Authorized to Disclose Patient's Health Information:**

_____
Name of Health Care Provider/ Other

_____
Street Address

_____
City/State/Zip

3) **Persons Authorized to Receive Patient's Health Information:**

_____
Name of Health Care Provider/ Other

_____
Street Address

_____
City/State/Zip

4) **Delivery Options:** ☐ Mail
☐ Hand Carry/ Pick up (Date & Time) _____
☐ Authorized Person to Pick-Up _____

5) **Health Information to be disclosed:**
☐ Medical History ☐ Progress Notes ☐ Consultations
☐ Laboratory Reports ☐ Radiology Reports ☐ Other _____
For the following dates: _____

6) **I Do Not want the following health information disclosed:**
☐ Human Immunodeficiency Virus Test Results ☐ Mental Health Records
☐ Developmental Disability Records ☐ Alcohol & Drug Abuse Records
☐ Other: _____

7) **Purpose for Need of Disclosure:** ☐ Further Medical Care ☐ Legal Investigation
☐ Insurance Eligibility ☐ Other: _____

8) **Your Rights With Respect to This Authorization:**

Right to Inspect or Copy the Health Information to be Used or Disclosed for this Authorization:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

Right to Receive Copy of This Authorization:
I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of this Authorization.

Right to Refuse to Sign This Authorization:
I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Right to Revoke This Authorization:

I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of my/ the patient's health information (i) already make in reliance on this Authorization by the person(s) and or organization(s) listed in Section 2 and 3 of this Authorization or (ii) if this Authorization was obtained as a condition of obtaining insurance coverage, to the extent that such person(s) and/ or organization(s) have the right to contest a claim under the policy pursuant to which such coverage is provided, or the policy itself.

9) **Expiration Date: This Authorization is good until the following date**: _____

If no date is specified, this Authorization will expire one (1) year from the date signed.

Prohibition on Re-Disclosure: This information is protected by Federal and North Carolina confidentiality laws. Such laws prohibit 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 such laws. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

10) **Signature of Patient/ Legal Rep:** _____Date: _____

Relationship or Authority to Act for the Patient_____

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child because such placement would endanger the child's physical, mental, or emotional health.)

11) **Witness (when applicable):** _____

Relationship _____ Date _____