SYMPHONY HEALTHCARE, INC.
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name _____ Birth Date _____ Gender __ Male ___Female

SS # _____ ____*(Required if we are billing insurance or in order to accept checks)*

Address _____ _____ _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Marital Status ___Single ___Married __ Divorced ___Widowed

Employer Name _____ Occupation _____

In case of emergency _____ _____ _____
Name Phone # Relationship

PERSON RESPONSIBLE FOR ACCOUNT (Guarantor)

_____Same as patient

Name _____ Birth Date _____ Gender ___Male ___Female

SS # _____*(Required if we are billing insurance)* Relation to Patient _____

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

Preferred Pharmacy _____
Name Location Phone #

What lab is your insurance contracted with? _____ **(We will use Quest if not noted)**

How did you hear about us? _____

I authorize and direct Symphony Healthcare, Inc. to perform medical evaluation and treatment upon me. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcomes of the treatments. With my signature below, I grant consent without duress, confusion or pressure from Symphony Healthcare, Inc.

Furthermore, I authorize Symphony Healthcare, Inc. to release any and all medical records required by the insurance company in order to process claims. Payment of all services is assigned to Symphony Healthcare, Inc.. I understand I am responsible for charges not paid by my insurance carrier within sixty (60) days of service within the limits of my policy and that payment of co-payment and/or co-insurance (including deductibles) is required at the time of service.

*

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance owed. I also authorize Symphony Healthcare, Inc. or insurance company to release any information required to process my claims.

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY DIAGNOSIS (✔ all that apply)	Self	Mother	Father	Sister	Brother	G-Mother	G-Father	Child
Allergy (Seasonal/Food)								
Anemia								
Anxiety								
Arthritis								
Asthma								
Blood Transfusion								
Breast Cancer								
Cataracts								
Colon Cancer								
Depression								
Diabetes								
Drug/Alcohol Abuse								
Emphysema								
Endometriosis								
GI Problems								
Headaches/Migraines								
Hearing Problems								
Heart Attack								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Irritable Bowel Syndrome								
Kidney Problems								
Lung Disease								
Mental Illness								
Neurological Disease								
Prostate Disease								
Sexually Transmitted Disease								
Skin Issues/Rashes/Itchiness								
Sinus Infections, Chronic								
Stroke								
Thyroid Problems								
Other:								

GENERAL INFORMATION

Tobacco Use ( )Current ( )Former ( )Never
Packs/day _____ Year started _____ Year quit ___

Alcohol Use ( )Current ( )Former ( )Never
How often ( )Daily ( )Weekly ( )Social ( )Rare

Caffeine Use ( )Current ( )Former ( )Never
How often ( )Daily ( )Weekly ( )Social ( )Rare

Sexually Active ( )Yes ( )No

Exercise ( )Yes ( )No

Vaccine History (date of last)

_____Flu _____TdAP (Tetanus)
_____Pneumonia _____Shingles
_____Varicella _____Other:

WOMEN ONLY

Age menses began: _____
Regular menses?: ( )Yes ( )No

Date of last:

Cyle _____ Pap _____
Mammogram _____
Bone Density _____
Colonoscopy _____
Dental Exam _____
Eye Exam _____
Total # of pregnancies _____
Total # of births _____
Method of birth control _____
Age of menopause _____

Do you experience any of the following symptoms:

_____Fatigue _____Trouble Sleeping
_____Hot Flashes _____Night Sweats
_____Depressive Mood _____Anxiety
_____Memory Loss _____Irritability
_____Weight Gain _____Low Libido
_____Vaginal Dryness _____Headaches
_____Joint Pain _____Hair/Skin Issues

MEN ONLY

Date of last:

Prostate Exam _____
Blood PSA Level _____
Colonoscopy _____

Do you experience any of the following symptoms:

_____Fatigue _____Trouble Sleeping
_____Depressive Mood _____Anxiety
_____Memory Loss _____Irritability
_____Weight Gain _____Hair Loss
_____Headaches _____Joint Pain
_____Low Libido _____Shrinking Testicles
_____Erectile/Sexual Dysfunction
_____Decreased Muscle Strength

MEDICAL HISTORY

SURGICAL/HOSPITALIZATION HISTORY

(Please include reason for surgery/hospitalization, date, and doctor that performed):

Reason	Date	Doctor

MEDICATION LIST

Medication Name and Dose	Instructions (how often do you take?)	Prescribed by

ALLERGIES TO MEDICATIONS

Name of Medication	Type of Reaction

OTHER MEDICAL PROVIDERS

Name of Provider	Specialty	What Condition is being managed?

SYMPHONY HEALTHCARE, INC.

NOTICE OF FINANCIAL OBLIGATION

I understand and agree that:

- I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any fees or services provided by Symphony Healthcare, Inc.
- It is my responsibility (and not the responsibility of Symphony Healthcare, Inc.) to know if my insurance will pay for my visit and/or if a prior authorization is required. I agree to make full payment for any and all denied claims for any reason.
- It is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-pocket, or any other benefit limitation or exclusion for the services I receive, and I agree to make full payment.
- It is my responsibility to know if Symphony Healthcare, Inc. is a contracted in-network provider recognized by my insurance company or plan and that if any claims are denied or result in higher out-of-pocket expenses to me that I agree to be financially responsible and make full payment.
- There are certain times when diagnostic tests and recommendations will be ordered as part of my health care. These tests include, but are not limited to: laboratory tests, radiology imaging, prescriptions, procedures, and referrals to other health care providers. I understand that it is my responsibility to understand what services are covered or non-covered by my insurance company since Symphony Healthcare, Inc. does not verify benefits with other health care providers or facilities. I understand that I have the right to refuse any service that has been recommended but I will be required to sign the Informed Consent/Refusal Form.

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members or others to call and request the results of tests, procedures, billing issues, or appointment scheduling. Under the requirements of HIPAA, we are not allowed to give any information to anyone without your written consent. If you wish to authorize anyone to obtain any information from Symphony Healthcare, Inc., please provide the individual names and phone numbers. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #

COMMUNICATION AUTHORIZATION

I understand that as part of my health care and treatment, Symphony Healthcare, Inc. may need to reach me for various reasons.

I (__) **DO** (__) **DO NOT** authorize Symphony Healthcare, Inc. to leave voicemail/text messages regarding communication of my health care, treatment, instructions, procedures, clinical information, billing, and/or appointment needs.

I (__) **DO** (__) **DO NOT** authorize Symphony Healthcare, Inc. to email me at the email address provided on the Registration Form regarding communication of my health care, treatment, instructions, procedures, clinical information, billing, and/or appointment needs.

PROTECTED HEALTH INFORMATION (PHI)

Symphony Healthcare, Inc. will use and disclose your PHI to provide, coordinate, or manage your health care needs. Your PHI will be used, as needed, to obtain payment for your health care services. Your PHI will never be released without written & signed consent from you, unless we receive a judicial subpoena or is a result of a request from your insurance company which has a blanket authorization from you. You have the right to inspect and copy your PHI. You have the right to request restriction of your PHI. This means you may ask us to restrict parts of your PHI to be released or disclosed. You have the right to receive confidential communications. You have the right to request an amendment to your PHI. You have the right to receive an accounting of certain disclosures. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you as we are required by law to maintain and respect the privacy of PHI.

I have read and understand the Notice of Financial Obligation, Authorization to Release Information, Communication Authorization, and Protected Health Information.

PRINTED PATIENT NAME	**SIGNATURE**	**DATE**

SYMPHONY HEALTHCARE, INC.

DEBORA DONAHUE, APRN
1317 SE 25th LOOP, SUITE 101
OCALA, FL 34471
352-629-5939~~352-629-7833 FAX

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ SS#_____ DOB_____
(Please Print)

HEREBY AUTHORIZE SYMPHONY HEALTHCARE, INC. TO: OBTAIN____ *RELEASE*_____

Doctor/Facility	PHONE#	FAX NUMBER
_____	_____/_____	
_____	_____/_____	
_____	_____/_____	

THE PATIENT RECORDS IN YOUR POSSESION:

~LABORATORY STUDIES_____ ~DIAGNOSTIC/TESTING_____ ~OTHER_____

CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM_____TO_____

THE PURPOSE OF REQUEST (PLEASE MARK)

CONCURRENT CARE_____ MOVING_____ TRANSFERRING_____ SELF_____ INSURANCE____

I specifically consent to the release of any material in your possession, including, if any, existing results of HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho emotional issues. I understand that I do have the right to limit the release of this information at anytime by putting my request in writing.
I request the provider named above promptly honor this request for medical information and/or copies of medical records. A copy of this request is as valid as the original. This authorization and request is valid for a period of one year from the date signed below, unless I request in writing to have this authorization revoked. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I may inspect and obtain a copy of any information disclosed. I may be charged a fee of $1.00 per page plus a $10.00 processing fee for personal copies.

PATIENT
SIGNATURE(X)_____DATE_____

_____
Address City Zip

_____
Telephone Number Other

Faxed by:_____Date_____.