South Baldwin Medical Group

Patient Registration Form

Please fill out form completely

Patient's Full Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ☐ M ☐ F **REASON FOR VISIT:** _____

Street Address/ APT#: _____

_____ How did you hear about us? ☐ Internet ☐ Family/Friends

City, State, Zip: _____ ☐ Healthcare Provider ☐ Healthy Women ☐ Senior Circle

Home Phone: _____ Home Email Address: _____

Cell Phone: _____ Emergency Contact: _____

Best form of contact: ☐ Home ☐ Cell Emergency Contact Phone: _____

Okay to leave a message? ☐ Yes ☐ No Relationship to Patient: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Primary Care Phone or City & State: _____

Based on government regualtions we are required to ask the following information: ☐ I prefer not to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other Race: ☐ American Indian or Alaska Native ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Black or African American ☐ Caucasian

☐ Non Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Guarantor Information ☐ Check if same as patient information and sign at X below. If not, please complete entire section and sign.

Name: _____ Sex: ☐ M ☐ F Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Date of Birth: _____ SSN#: _____

Street Address/Apt#: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Assignment of Benefits and Gurantee of Account:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to collection agency, I agree to pay all costs of collection fees and/or attorney's fee and all court costs if any.

X: _____ Date: _____

Patient/ Guarantor Signature

Insurance Information

Primary Insurance

Insurance Plan Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy ID: _____ Group: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance (if applicable)

Insurance Plan Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy ID: _____ Group: _____ Subscriber Name: _____

Subscriber Date of Birth: _____

CONSENT FOR TREATMENT I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment. I understand that this consent will last for one (1) year from today's date and will expire at the end of one year unless terminated in writing by me at an earlier date.

Signature: _____ Date: _____

Patient/Guardian Signature (if patient is a minor)

South Baldwin Medical Group

Patient Portal Consent Form

These terms and conditions constitute a binding agreement between you and South Baldwin Medical Group.

South Baldwin Medical Group patient portal is an internet based tool that allows patients to view and access their health records.

The patient portal may not contain a complete copy of your health records at all times. South Baldwin Medical Group has the right to restrict disclosure of certain records to you under federal and state law. Please refer to South Baldwin Medical Group's Notice of Privacy Practices for a complete description of how your medical information may be used and disclosed.

By providing the email address below, you agree that South Baldwin Medical Group may send to the email address a confidential user ID and password or a link to create a confidential user ID and password which will provide you access to the patient portal. You agree and understand that protection of this confidential login information is up to you and not the responsibility of South Baldwin Medical Group once we have provided you with the initial email. You further acknowledge that South Baldwin Medical Group will use this email address as our means of communicating to you regarding information sent to the patient portal. Communicating via the patient portal is not intended for medical treatment purposes. If you have a life threatening emergency, please call 911 and seek medical attention immediately.

By accessing or using the patient portal, you confirm that you agree to these terms and conditions. If you do not agree, then do not use the patient portal. By agreeing to these terms and conditions, you acknowledge that you are at least 19 years of age and that you are requesting access to the patient portal. You acknowledge that the patient portal is offered as a courtesy to our patients and you agree that we may terminate your access to the portal at any time for any reason with or without notice.

☐ Yes, I consent. ☐ No, I do not consent.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ (format: "MM/DD/YYYY")

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

Personal Phone Number: _____ (format: "555-555-5555")

Personal Confidential Email Address: _____ @_____ . _____

Signature: _____ Date: _____

Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your Protected Health Information (PHI). This Notice describes how South Baldwin Medical Group and it Entities[1] will treat your PHI and how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. South Baldwin Medical Group and its Affiliated Entities may share your health information for treatment, payment and health as described in this Notice. This Notice applies to all services provided at South Baldwin Medical Group and its Affiliated Entities. This Notice also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by the physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred or are receiving treatment from to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used to obtain payment for your health care services. For example, we may provide PHI to your insurance company to obtain authorization and payment for services rendered. We may contact the Guarantor for your visit in order to obtain payment.

Healthcare Operations: We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign-in sheet at the registration desk where you will be asked to provide your name and insurance company. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

We may use or disclose your PHI in the following situations without your authorization: As required by Law, for Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, to avert a serious and imminent threat to a person or the public, National Security, Worker's Compensation, Inmates, and other Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

Other permitted and required uses and disclosures, such as for marketing or sale of your PHI to third parties, will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in, a legal proceeding, and PHI that is otherwise prohibited.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any restriction that you may request and if we believe it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another health care professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location by notifying us in writing.

You have the right to obtain a paper copy of this notice from us, upon request.

You may have the right to ask us to amend your protected health information. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Your request must be in writing. We are required by law to notify you if your unsecured PHI is breached.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated.

We reserve the right to change the terms of this notice. Any change will apply to all PHI that we maintain.

South Baldwin Medical Group

_____	_____	_____
Signature	**Print Name**	**Date**

[1] South Baldwin Surgical Associates, South Baldwin Medical Center Gulf Shores, South Baldwin Medical Group at Glen Lakes, South Baldwin Medical Partners, Gulf Shores Family Medicine, South Baldwin Neurology, South Baldwin Medical Group at Mckenzie Street, Foley Walk In Med Care, Central Baldwin Immediate Care & Family Practice, South Baldwin Medical Group at Orange Beach, South Baldwin Hospitalist Group

South Baldwin Medical Group

Office Visit
Authorization For Release Of Medical Records

Patient Name: _____

Patient DOB: _____ Patient SSN: _____

Name of Individual Requesting Release: _____
Relationship to Patient: ☐ Self ☐ Parent/Guardian of minor under age 14 ☐ Legal Counsel- provide copy of legal representation document ☐ Other- specify: _____

I hereby authorize South Baldwin Medical Group to release the following about me as described below.

Name & phone number of the Individual(s) to whom medical records or information may be released:

☐ Spouse/Significant Other: _____ ☐ Medical ☐ Financial

☐ Parent(s): _____ ☐ Medical ☐ Financial

☐ Other: _____ ☐ Medical ☐ Financial

☐ Other: _____ ☐ Medical ☐ Financial

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508©),

- I request and authorize release of the information described above to the party named.
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the entity named above.
- I may refuse to sign this authorization and such refusal will not affect my treatment.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a copy of this signed authorization.

_____ _____
Patient, Guardian, or Authorized Patient Representative Signature Date

_____ _____ _____
Relationship to Patient Authorization Begins (Date) Authorization Expires: Expires 1 year from begin date if blank