YELLOW SPRINGS PRIMARY CARE

888 Dayton Street, Suite 106 Yellow Springs, OH 45387
(937) 767-1088 Office / Fax (937) 767-1022

PATIENT REGISTRATION FORM

Date	PCP (Please Check One) ☐ Donald Gronbeck, MD ☐ Sarah Teegarden, CNP

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (Circle One) Single / Married / Divorced Separated / Widow(er) / Partner
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date:	Age:	Sex: ❑ M ❑ F
Street address:		Social Security No..:		Home Phone No..:
P.O. box:	City:	State:	ZIP Code:	Cell Phone No.
Previous Physician Name:	Address:			Phone Number:

Chose practice because/Referred to practice by (please check one box):

❑ Dr.__________________________________ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work

❑ Yellow Pages ❑ Other ______________________________ Other family members seen here: ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Home Phone No. Cell Phone No.
Relationship to patient:	Work Phone No.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Financial Guarantor :	Birth date:	Address (if different from patient):	
Is this person a patient here? ❑ Yes ❑ No			
If Yes, Name:		Home Phone No.:	Work Phone No.:
Occupation:	Employer address:		
Is this patient covered by insurance? ❑ Yes ❑ No		Name of Primary Insurance:	
Subscriber's name:		Policy No..:	
Subscriber's S.S. No..:	Birth date:	Group No..: Co-payment: $	
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name Of *Secondary* Insurance:		Policy No..:	
Subscriber's name:		Group No..:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Yellow Springs Primary Care (YSPC) has the right to change its Notice of Privacy Practices that will be effective for health information for myself as well as any care I receive in the future. YSPC will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with Federal governmental privacy rules implemented through the Health Care Portability and Accountability Act of 1966 (HIPAA), for healthcare provider or staff of Yellow Springs Primary Care to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived with your written approval.

☐ I do not authorize Yellow Springs Primary Care to release any information regarding my medical condition.

☐ I do authorize Yellow Springs Primary Care to release any and/or all information to the following people:

NAME	RELATIONSHIP TO PATIENT

I authorize YSPC to contact me via the following methods:

☐ Phone	☐Home	May we leave a Voicemail? ☐Yes ☐No	If Yes ☐ Detailed ☐Generic
	☐Mobile	May we leave a Voicemail? ☐Yes ☐No	If Yes ☐ Detailed ☐Generic
	☐Work	May we leave a Voicemail? ☐Yes ☐No	If Yes ☐ Detailed ☐Generic

☐ Email (Email Address) ____ If Yes ☐ Detailed ☐Generic

NOTICE OF FINANCIAL RESPONSIBIUTY

BILLING GUARANTOR

I understand that payment of co-pays and/or self-pay visits are due at the time of service. The patient, parent, or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs Incurred in the collection of a patient's account in case of default, including any reasonable attorney fees and court costs. I also agree to pay the $35 Returned check fee for insufficient funds to my account for bounced checks.

I hereby grant permission to Yellow Springs Primary Care (YSPC) or my insurance company to release any information required to process my claims, and I also authorize payment directly to Yellow Springs Primary Care (YSPC). Additionally, a photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Yellow Springs Primary Care (YSPC) may be considered "non-covered" by my insurance carrier, Medicare, or Medicaid; therefore, I will become fully responsible for payment of these services.

PLEASE CHECK THE BOX BELOW:
☐ I have read all the above and understand/agree to all provisions therein regarding financial responsibility.

Patient Printed Name:	*Legal Guardian Printed Name*
Patient/Guardian signature:	*Date:*