APEX MIGRANT AND TRAVEL MEDICINE, LLC
REGISTRATION FORM

Today's Date: | REASON FOR VISIT (Circle One): IMMIGRATION / TRAVEL MEDICINE

PATIENT INFORMATION

Last Name: First: Middle:

☐Mr. ☐Mrs. ☐Ms.

Marital status: ☐Single ☐Mar ☐Div ☐Sep ☐Wid

RACE/ETHNICITY: CAUCASIAN, BLACK, LATINO, ASIAN, NATIVE AMERICAN, OTHER_____

LANGUAGE: ENGLISH, SPANISH Other_____

Birth Date: **Age:** **Sex:** ☐M ☐F

Address: Social Security no.: Home phone no.: ( )

Cell phone no: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

EMAIL ADDRESS:_____

MEDICAL HISTORY

PAST MEDICAL HISTORY (anemia, kidney, seizures, thyroid, etc.):_____

PAST SURGERIES:_____

ALLERGIES: (Drugs, Food, Latex, Eggs) _____

MEDICATIONS: (Dosage, Regimen) _____

FAMILY MEDICAL HISTORY:_____

Travel Medicine Patients Only:

DEPARTURE DATE: _____ **RETURN DATE:** _____ **TOTAL STAY LENGTH:** _____

DESTINATION (City, Country) : _____ **RURAL?** YES / NO **RESIDENCE** (Hotel, Home, Hostel, etc.) _____

DO YOU HAVE G6PD DEFICIENCY? YES / NO **ARE YOU IN TREATMENT FOR CANCER OR OTHER MALIGNANT DISEASE?** YES / NO

DO YOU HAVE OR LIVE WITH SOMEONE WHO HAS IMMUNE SYSTEM DEFICIENCY? YES / NO

Women: **ARE YOU PREGNANT OR BREASTFEEDING?** YES / NO

SOCIAL HISTORY

Please circle one of each category:

LIVES WITH: Alone , Family, Roommate, Partner *List* _____

EXERCISE: Yes, No *Type /Amount*_____ **TOBACCO:** Current, Never, Past Use/ *Quit Date*_____ *Type/ Amount*_____

ALCOHOL: Occasional , Daily Weekly, Rarely, Never, Past (1-2x wk) (3-4x wk) **DRUG USE:** Current, Never, Past Use *Type/Amount*_____

SEXUAL HISTORY: Circle one (Sex with men) (Sex with Women)(Sex with men and Women) (Monogamous) (Multiple Partners) (Not sexually active)

IN CASE OF EMERGENCY

Name of friend or relative | Relationship to patient: | Home /Cell phone no.: ( ) | Work phone no.: ( )

By signing this form, I give my consent to be treated by the medical providers of this practice. I allow the providers and staff of APEX to give me the needed medical treatment and services they recommend.. I understand treatment and services may include: lab tests, screening tests, immunizations, diagnostic tests and routine exams.

I understand that no promises have been made to me about the results of any treatment or service. The above information is true to the best of my knowledge. I understand that Apex Migrant and Travel Medicine does not participate with any health insurance including Medicare and Medicaid. I understand that I am financially responsible for all services rendered to me today.

Signature: _____ Date:_____

APEX Travel & Migrant Medicine, LLC

2175 K St, Suite C100, NW Washington, DC 20037
Tel: 202-293-5001, Fax: 202-293-5011

Patient Name _____ Date of Birth _____

HIPPA

The Health Insurance Portability and Accountability Act (HIPAA), was created in 1996 by the US Congress to protect the privacy of patient's health information. The act prohibits your healthcare provider from releasing your health care information unless you have provided with a HIPAA release form. Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care. Please refer to Apex's Notice of Privacy Practices (available in paper copy at the receptionist desk or online) for a more complete description of such uses and disclosures.

Release of Information

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. The information may be released to:

- ☐ Spouse Name: _____ Phone# _____
- ☐ Children Name(s): _____ Phone# _____
- ☐ Other: _____ Phone# _____
- ☐ Do not release my medical information to anyone

Note: This release of medical information will be in effect until terminated by you in writing.

Email Correspondence

We may need to contact you regarding your personal healthcare information. This information includes test results, referral information, scheduling, canceling, or confirming appointments as well as any other medical information pertinent to your care. **We will NOT send you spam.** Our practice will use email as the primary means of contacting you, unless you specifically decline email communication. Please select an option below to communicate your preferences.

- ☐ Yes, please send me email correspondence to communicate with me regarding my personal healthcare information at: *Email Address* _____
- ☐ No, I do not wish to be emailed. I would only like to receive phone calls.

Please Note: By utilizing our services or replying to our emails, you acknowledge that you are aware that email is not a secure method of communication, and that you are aware of the risks. If you prefer not communicate via email, please specify above.

Telephone Correspondence

Please call: [ ] My cell #_____ [ ] My home #_____ [ ] My work #_____

If unable to reach me (check all that apply):

- ☐ You may leave a brief message asking me to return your call
- ☐ Other: _____

Patient's Bill of Rights

As a patient of **Apex Travel & Migrant Medicine**, you have the right to:

- ✓ Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- ✓ Receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.

APEX Travel & Migrant Medicine, LLC
2175 K St, Suite C100, NW Washington, DC 20037
Tel: 202-293-5001, Fax: 202-293-5011

- ✓ Be told by your healthcare provider about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment.
- ✓ Expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments.
- ✓ Be an active participant in your healthcare, including understanding and discussing various treatment options and test results. You have the right to accept or reject a treatment plan.
- ✓ Access your medical records.
- ✓ A second opinion; our healthcare providers will refer your case to another healthcare provider or specialist per request.

Patient's Responsibilities

As a patient of **Apex Travel Medicine**, you are expected to:

- ✓ Provide complete and accurate information, including:
  - o Personal information (full name, date of birth, social security number, address, phone number, employer);
  - o Medical and surgical history, medicines, allergies, supplements, and any other matters that pertain to your health and safety.
- ✓ Ask questions when you do not understand information or instructions.
- ✓ Tell your healthcare provider if you believe you cannot follow through with your treatment plan.
  - o You are responsible for your outcomes if you do not follow the care, treatment, and service plan prescribed.
- ✓ Be an active participant in your health.
- ✓ Keep appointments, be on time, and call the office if you cannot keep your appointments.
- ✓ Treat all staff, healthcare providers, other patients and visitors with respect; and, abide by practice policies and safety regulations.
- ✓ Pay your bills in a timely manner.

Patient Financial Policy for APEX TRAVEL & MIGRANT MEDICINE, LLC

The patient (or patient's guardian, if a minor) is responsible for the payment for his/her treatment and services rendered. Payment is due at time of service. For those patients whose Medical Insurance covers vaccine services, we will give you a claim form to submit to your insurance on your own, for direct reimbursement for vaccine and travel services rendered. Please note that **APEX TRAVEL & MIGRANT MEDICINE DOES NOT** have a participatory contract with any third party payer and that the practice is considered an **OUT OF NETWORK** facility.

I understand that APEX TRAVEL & MIGRANT MEDICINE does not accept ANY health insurance including Medicare and Medicaid. I am solely responsible for any and all payments for VACCINE and other services rendered to me.

I agree that I have been fully informed of the practice's HIPPA Privacy Policy, Patient Rights and Responsibilities, and the Financial Policy.

_____ _____

Signature of Patient or Guardian Date of Service