APEX PRIMARY CARE GROUP, LLC
REGISTRATION FORM

Today's Date:	REFERRED BY:

PATIENT INFORMATION

Last Name: First: Middle:	☐Mr. ☐Mrs. ☐Miss ☐Ms.	Marital status: ☐Single ☐Mar ☐Div ☐Sep ☐Wid

RACE/ETHNICITY: CAUCASIAN, BLACK, LATINO(A), ASIAN, NATIVE AMERICAN, OTHER_____	**LANGUAGE**: ENGLISH, SPANISH Other_____	**Birth Date:**	**Age:**	**Sex:** ☐M ☐F ☐Other

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

Cell phone no:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

EMAIL ADDRESS:_____

INSURANCE INFORMATION

Insurance Company :**Member ID #**: **Group #**:

Person responsible for bill:	Birth date:	Address (if different):	**Phone :** **(C) (H)**

MEDICAL HISTORY

REASON FOR TODAY'S VISIT:_____

PASTMEDICAL HISTORY:_____

PAST SURGERIES:_____

MEDICATION: (Vitamins, Supplements, prescriptions, etc.)_____

ALLERGIES: (Drugs, Food, Latex) _____

SOCIAL HISTORY

Please circle one of each category:

LIVES WITH: (Alone , Family, Roommate, spouse, etc) _____ **DIETARY RESTRICTIONS:** (i.e. vegan, vegetarian, etc): _____

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

ALCOHOL: How many days/week you drink beer, wine, or liquor _____ **DRUG USE:** Current, Never, Past Use *Type/Amount*_____

SEXUAL HISTORY: **Sex with: men, women, or both**_____ **Activity:** one partner, multiple partners, not sexually active _____

FAMILY MEDICAL HISTORY:_____

_____

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, 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 authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims.

Signature: _____ Date:_____

Apex Primary Care Group, LLC

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

_____ _____
Patient Name Date of Birth

APEX HIPPA POLICY IN ACCORDANCE WITH THE 1996 ACT

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 (APEX) from releasing your health care information unless you have provided APEX with a HIPAA release form. Unless you have provided a signed release form, we as your providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care. Please refer to the following website for a more complete description of such uses and disclosures :https://www.hhs.gov/hipaa/for-individuals/index.html. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations

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 will 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:_____

Mailing Correspondence

- ☐ Yes, please send mail to communicate with me regarding my personal healthcare information at:
  Mailing Address _____
- ☐ No, I do not wish to receive mail.

Patient's Bill of Rights

As a patient of Apex Primary Care, 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.
- ✓ 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 Primary Care, you are expected to:

- ✓ Provide complete and accurate information, including:
  - Personal information (full name, date of birth, social security number, address, phone number, employer);
  - Insurance information; and,
  - Medical and surgical history (current and past medical conditions, hospitalizations, surgeries, 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.
  - 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.
- ✓ Be familiar with your insurance plan including your plan's co-pay, deductible, and benefit package.
- ✓ Pay your bills in a timely manner.

Patient Financial and Insurance Policy

- ✓ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
- ✓ We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- ✓ For uninsured and self pay patients, payment for services rendered is due at time of visit, and are non-refundable.
- ✓ Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at time of service.
- ✓ Please be aware that Apex will utilize the services of collections agencies for monies due for unpaid account balances after several attempts to collect payment.

Appointment Cancellation, No-Show and Rescheduling Policy

- ✓ Any **appointment that is not cancelled or rescheduled up to 24 hours in advance will result in a $25 charge billed to your account**. 'No show' and 'non-cancellation' fees are not billed to insurance.

By my signature below, I hereby authorize assignment of financial benefits directly to Apex Primary Care Group for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. I agree that I have been disclosed of the HIPPA Privacy Policy, Email and Telephone Correspondence Policy, Patient Rights and Responsibilities, and Patient Financial and Insurance Policy as contained in this document.

_____ _____

Signature of Patient or Guardian Date of Service