Patient Registration

Penn Highlands Life's Journey

Name: ______________________________ Date of Birth*:____/____/____

Social Security Number:__________________ Primary Language*:___________

Contact Phone Numbers: Home(___)____-_____ Cell: (___)____-______

Address: ____

City/State/Zip Code: ____

Email Address: ____

Race*: (please circle) Asian White Black/African American
Hispanic or Latino Other

Ethnicity*: (please circle) Non-Hispanic/Latino Hispanic/Latino Mexican
Puerto Rican Cuban Other

Who do we contact in case of emergency:

First Emergency Contact: ___________________ ___________ ___________

Name	Phone #	Relationship

Second Emergency Contact: _________________ ___________ ___________

Name	Phone #	Relationship

Patient Name: ______________________________

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT (HIPPA)

This disclosure contains information regarding the privacy of your personal healthcare information.

By signing the disclosure, I acknowledge that Penn Highlands Life's Journey may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered.

☐ I have read and understand the policy, but choose ***not to receive a copy.***

☐ I have read and understand the policy and would like to obtain a copy

Signature: ______________________________ Date: ______________________________

This signature ensures that your health information and condition will not be discussed with other family member(s) or person(s) unless you specifically give your permission.

By my signature below, I grant Penn Highlands Life's Journey permission to discuss my protected medical information with the following individuals:

	Name	Phone #	Relationship
1.	____________	____________	____________
2.	____________	____________	____________
3.	____________	____________	____________

Signature: ______________________________ Date: ________________

Messages and Phone Calls:

Penn Highlands Life's Journey can contact me and/or the person(s) listed above via: (check all that apply):

Home Phone____ Cell Phone____ Text Message____ Email ____ Mail____ Work Phone____

Can Penn Highlands Life's Journey leave a message?: YES____ NO_____

Patient Name: ______________________________

Reason for Today's Visit

_____ Initial Obstetrical Visit

_____ Routine Preventative Exam (Annual)

_____ I am having problems I would like to discuss today

_____ Other

Payment Policies

Please read and initial beside each paragraph below.

_____ *A routine preventative exam (annual) includes a medical history, physical exam and testing to screen for asymptomatic diseases and renewal of maintenance medications. Should any problems/issues outside of a routine exam be addressed today, there may be additional charges, including copayments and/or deductible and co-insurance.*

_____ *We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Patient is responsible to pay any non-covered charge and/or fee applied to their deductible, co-insurance or copay. Questions about non-payment should be directed to your insurance company.*

_____*As a courtesy, Penn Highlands Life's Journey, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.*

Patient Name: ______________________________

Authorization for Release and Assignment:

I authorize Penn Highland Life's Journey to release information to insurance carriers concerning my illness and treatments for the purpose of payment. I assign all payments for medical services rendered to myself and my dependents to Penn Highlands Life's Journey. I understand I am responsible for any amount not covered by my insurance including co-pays, deductibles and non-covered services.

Signature: ______________________ Date: __________

Consent to Treatment:

I consent to examination and/or medical care as prescribed by the physician. This authorization is in force unless revoked in writing.

Signature: ______________________ Date: __________

Cancellation/No Show Policy:

Please call at least 24 hours before your office visit to cancel an appointment. If you are rescheduling an appointment, please let us know so that we can cancel it and open the time for another patient.

If you no show for two consecutive appointments or no show for three total appointments, you may be discharged from the practice. Penn Highlands Life's Journey will notify you in writing, via certified mail, if you are discharged from care.

As emergencies arise with my regular scheduled provider, I acknowledge that I may be seen by another Penn Highland Life's Journey provider without notice.

Signature: ______________________ Date: __________

Medication Screening:

Penn Highlands Life's Journey intends to make sure that when prescribing medications to our patients that they are being taken as prescribed. In order to do this, we have instituted steps that include random screening for drug and alcohol use. The results of these test will be used to customize your care here at Penn Highlands Life's Journey. If it is determined that prescription drugs are not being taken as prescribed or that there is a potential issue with recreational use of drugs and alcohol, counseling will be provided. We encourage all of our patients to ask questions regarding the use of all prescriptions that we may prescribe.

Signature: ______________________ Date: __________

For Patients with Commercial Insurance, Medicaid or Medicare with Secondary

Personal & Family Cancer History

Name: ______________________ Date ________ Date of Birth: ________ Age: ____

If you have Medicare with no secondary insurance, call for coverage before moving forward with cancer genetic testing.

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**

2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

		CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	Yes	BREAST CANCER diagnosed age 49 or younger for You or Relative					
No	Yes	OVARIAN CANCER for You or Relative					
No	Yes	Ashkenazi Jewish heritage with BREAST CANCER at any age					
No	Yes	3 or more BREAST, PROSTATE, and/or PANCREATIC CANCERS on one family side, any ages					
No	Yes	MALE BREAST CANCER					
No	Yes	2 or more COLON CANCERS on a family side, at least one under 50					
No	Yes	3 or more COLON or UTERINE CANCERS on a family side, any ages					

Patient Signature____

OFFICE USE ONLY Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: ________