**LeBauer Medical Center**
***Allergy, Asthma & Sinus Care***

**RANJAN SHARMA, MD** **MEG A. WHELAN, MD** **R. CHRISTOPHER VAN WINKLE, MD**

# PATIENT REGISTRATION SHEET

Patient Last Name_____First Name_____M.I._____
BIRTH DATE_____ GENDER (M/F)_____Marital Status_____
Address_____
City_____State_____Zip Code_____
***Email Address:_____***
***Phone #s: H) ( )_____ C) ( )_____ W)( )_____***
*PREFERRED PHONE for Us to Contact You (circle one) Home Cell Work*
*Primary Care Physician Name:_____ Referring Physician(if any)_____*

**Preferred Pharmacy and Address_____**

## *Race and Ethnicity Reporting*

Please Circle Race: Hispanic White African American Asian American Indian
Other Prefer not to report
Please Circle Ethnicity: Hispanic or Latino Not Hispanic Prefer not to report
Please Circle Language: English Spanish Indian Russian Other

## *Emergency Contact Information*

Relative to Contact in Emergency:_____Relation:_____ Phone #: _____
Alternate Emergency Contact:_____Relation:_____Phone #: _____

## *Primary Insurance Information*

Insurance Company Name:_____Policy Holder Name:_____
Policy Holder Date of Birth:_____ Relationship to Patient_____

## *Secondary Insurance Information*

Insurance Company Name:_____Policy Holder Name:_____
Policy Holder Date of Birth:_____ Relationship to Patient_____

### *Authorization of Benefits*

This medical practice works with its patients to minimize difficulty in the payment of fees for service. Prior to your appointment, you will be asked to pay those minimal unmet co-insurance amounts which your insurance company authorizes to be collected. Further, we automatically file insurance claims with your insurance company; therefore, please insure that your primary and secondary insurance information is current and accurate. By signing below you agree to be responsible for satisfying any unpaid balance left by your insurance company for the services you receive from our office. I hereby assign all medical and/or surgical benefits, to included major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to:
**LeBauer Medical Center, PLLC Allergy, Asthma & Sinus Care.**

**Patient or Responsible Party Signature_____**
**Today's Date:_____**

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# Authorizations

**Patient Name:_____**

**Patient Date of Birth:_____**

## MISSED APPOINTMENT POLICY

☐ I understand that LeBauer Medical Center does REQUIRE 24 hours advanced notice to cancel or re-schedule an appointment. I understand a fee may be charged to my account for missed appointments or appointments cancelled with less than the required notice.

## FORM FEES

☐ I understand that LeBauer Medical Center will charge for the completion of forms that require either staff or physician time to complete. The charge for this service will start at $10 depending on the complexity and time required. This includes, but is not limited to school forms, medication forms, letters, and FMLA forms. The fees may be waived (excludes FMLA) if the form is presented at an appointment to see the doctor or at a visit for the patient to receive an allergy shot and is picked up.

## CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I authorize LeBauer Medical Center and it's providers to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable the staff here, and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

☐ I certify that I read and understand the scope of my consent and that I authorize the access.

## CONSENT TO CONTACT VIA EMAIL:

To the extent that our new Medical Record software allows it, we may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare.

☐ I authorize LeBauer Medical Center to use the email address I provided above to contact me in regards to my healthcare. I consent that protected healthcare information may be transmitted to me via this email address.

## CONSENT TO COMMUNICATE PROTECTED HEALTH INFO

At my request, I also authorize LeBauer Medical Center to communicate my protected health information (including appointment reminders) to me via the following methods:

☐ Detailed message on my home answering machine
☐ Detailed message on my personally identifiable voice mail at work
☐ Detailed message on a personally identifiable cell phone voice mail

## TEXT MESSAGING

☐ It may be possible to contact you via text message for appointment reminders or other important communications. If you agree to receive messages please check the box and specify your preferred number (  )_____.

**Patient or Responsible Party Signature_____**
**Today's Date:_____**

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# Designated Party Release

You may give LeBauer Medical Center, PLLC written authorization to disclose your protected health information to anyone that you designate. That may be a family member or personal representative. If you wish to authorize a person to receive information regarding your care and/or accounting, please complete the form below. I also understand that information released under this agreement is not protected from further distribution by the designated party.

Patient Name:_____Date of Birth:_____

Today's Date:_____

At my request, I authorize LeBauer Medical Center, PLLC to disclose my protected health information to (Enter below the name of person/entity who you designate to be eligible to receive your protected health information):

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I understand that I have the right to cancel this authorization at any time. If in the future I wish to authorize cancellation I may request so in writing. However, if I cancel this authorization, I also understand that cancellation will not affect any action LeBauer Medical Center, PLLC took in reliance on this authorization before receipt of written notice of cancellation. I also understand that information released under this agreement is not protected from further distribution by the designated party.

**Authorized Signature**:_____
**Today's Date:_____**