Tim R Tarkenton, M.D., F.A.C.O.G.
Obstetrics and Gynecology
The Women's Pavilion

Patient Registration Form
(Please Print)

Patient Information

(Last)_____(First)_____(MI)_____

DOB_____Age_____SSN_____

Address_____APT_____

City, State, Zip_____

Home/Cell Phone_____Other Phone_____

Email Address_____Portal Access_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ☐ Declined

How did you hear about us? _____

Emergency Contact

Name:_____Relationship:_____DOB:_____

Address:_____City, State, Zip:_____

Phone:_____Other Phone:_____

Insurance Information **(Provide your insurance card(s) (primary, secondary, etc...) at check-in.**

Primary_____ Secondary_____

Policy/ID No_____ Policy/ID No_____

Group No_____ Group No_____

Policy Holder_____ Policy Holder_____

Relationship_____ Relationship_____

DOB_____ DOB _____

I authorize payment of medical benefits for services rendered, and the release of medical information requested by my insurance company. I also understand that if I do not provide correct insurance information, I will be responsible for all charges incurred.

_____ _____

Signature/Guardian Date

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Patient Consent for Financial Communications

Please Initial each section.

_____Financial Agreement

- I acknowledge, that as a courtesy, Tim R Tarkenton, M.D., F.A.C.O.G. may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks. (Current fee is $25.00).

_____Charges to Account: Tim R Tarkenton, M.D., F.A.C.O.G., has the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service.

_____Third Party Collection. I acknowledge Tim R Tarkenton, M.D., F.A.C.O.G. may use the services of a third-party business associate or affiliated entity as an extended business office("EBO Servicer") for medical account billing and servicing.

_____Assignment of Benefits. I hereby assign to Tim R Tarkenton, M.D., F.A.C.O.G. any insurance or other third-party benefits available for health care services provided to me. I understand Tim R Tarkenton, M.D., F.A.C.O.G. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Tim R Tarkenton, M.D., F.A.C.O.G. I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

_____Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Tim R Tarkenton, M.D., F.A.C.O.G.by the Medicare or Medicaid program.

_____Consent to Telephone Calls for Financial Communications. I agree that, in order for Tim R Tarkenton, M.D., F.A.C.O.G., or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Tim R Tarkenton, M.D., F.A.C.O.G. or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided Tim R Tarkenton, M.D., F.A.C.O.G. or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing dev ice, as applicable.
A photocopy of this consent shall be considered as valid as the original.

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_____**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and payments or credits applied to your account during the month.

Payment options if you have no insurance:

1. You choose to pay by ___ cash, ___ check, or ___ credit card on the day that treatment is rendered.
2. Please see front desk for other options of payment.

This is an agreement between Tim R Tarkenton, M.D., F.A.C.O.G., as creditor, and the Patient/Debtor named on this form. Payment is due at time services are rendered.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient/Guardian **Date**

_____

Please print name

_____

Relationship to patient

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Patient consent for E-Prescribing

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

_____ _____

Patient/Guardian **Date**

_____

Relationship to patient

Pharmacy:

1. _____ Address: _____

2. _____ Address: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Office designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice clinics.

Communication about My Healthcare

I understand I have certain rights to privacy regarding my protected health information. I agree the Provider, or an agent of the provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician

Consent for Photographing or Other Recording for Security and/or health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings.

I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Patient Name:_____ **Date:**_____

_____

Patient/Guardian Signature

_____

Relationship to patient

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Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to communication to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic used an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) with other providers may be made available to subsequent providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric report, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

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General Consent for Care and Treatment Consent

***TO THE PATIENT**: You have the right, as a patient to be informed about your condition, and the recommended surgical, medical, or diagnostic procedure, to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. by signing below, you are indication that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended: and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with you physician abut the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment and recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient/Guardian **Date**

_____ _____

Print name/Guardian **Relationship to Patient**

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ATTENTION PATIENTS!

There will be a **$25** charge to your account for any same day cancelations or rescheduling of appointments.

You must give **48hrs** notification for any cancelations or rescheduling.

If you will be more than 10 minutes late for your appointment you will be charged **$25** and you will need to reschedule.

This will not be sent to your insurance, and **YOU** will be responsible for the fee at your next appointment.

If you are a No-show **3** times, you will be dropped as a patient.

_____ _____
PATIENT/GAURDIAN DATE

_____ _____
PRINT NAME/GAURDIAN RELATIONSHIP