KENNETH H. FARRELL MD PA - PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name	Date of Birth	SSN

Address	City, State, Zip
Email	Employer

Home Phone	Work Phone	Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Other	Gender: ☐ Male ☐ Female
Primary Care Physician	Primary Care Phone
Preferred Pharmacy Name	Pharmacy Phone

EMERGENCY CONTACT

Contact Name	Relation to Patient	Phone
Contact Name	Relation to Patient	Phone

REASON FOR TODAYS VISIT - List the reason(s) for todays visit below

Is todays visit pertaining to a motor vehicle or workers comp injury? ☐ YES ☐ NO	If Yes, Date of Accident:

MEDICATIONS - List any medications that you currently take below.

Name of Medication	Dosage	Frequency

ALLERGIES TO ANY MEDICATIONS? ☐ YES ☐ NO (If YES, list them below)

Medication	Reaction
Medication	Reaction

RESPONSIBLE PARTY (GUARANTOR)

If you are providing the information above for a patient other than yourself, please complete the section below:

Name	Date of Birth	SSN

Address	City, State, Zip

PATIENT HEALTH QUESTIONNAIRE

SURGERIES / HOSPITALIZATIONS - List any surgeries / hospitalizations and the years for each.

Year	Surgery / Hospitalization

SOCIAL HISTORY - (Tobacco, Caffeine, Alcohol, Drug Use)

Do you smoke cigarettes? ☐ YES ☐ NO	If YES, how many years:	If YES, amount per day:
Do you consume alcohol? ☐ YES ☐ NO	If YES, what kind:	If YES, amount per day:
History of drug use? ☐ YES ☐ NO	If YES, what kind:	If YES, how many years?

How many cups of coffee / caffeine drinks do you consume daily?

FAMILY HISTORY - List any family history of major illnesses (cancer, diabetes, heart attacks, high blood pressure, etc)

Family Member	Illnesses

REVIEW OF SYMPTOMS

GENERAL:

HIV+ / AIDS	☐ YES	☐ NO
Weight Gain / Loss	☐ YES	☐ NO
Difficulty falling asleep	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Change in appetite	☐ YES	☐ NO

EYES:

Wear glasses	☐ YES	☐ NO
Decreased vision	☐ YES	☐ NO
Pain in eyes	☐ YES	☐ NO

EARS, NOSE, THROAT, MOUTH:

Difficulty or changes in hearing	☐ YES	☐ NO
Earaches	☐ YES	☐ NO
Discharge from ears	☐ YES	☐ NO
Buzzing or ringing in ears	☐ YES	☐ NO
Frequent sneezing	☐ YES	☐ NO
Nose stuffiness or running	☐ YES	☐ NO
Recurrent sore throat	☐ YES	☐ NO
Persistent hoarseness	☐ YES	☐ NO
Dental problems	☐ YES	☐ NO
Sinus problems	☐ YES	☐ NO
Lymph glands or nodes	☐ YES	☐ NO
Frequent nose bleeds	☐ YES	☐ NO

NEUROPSYCHIATRIC:

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Frequent or severe headaches	☐ YES	☐ NO
Dizziness or faintness	☐ YES	☐ NO

CARDIOVASCULAR:

Chest pain	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Abnormal swelling in legs/feet	☐ YES	☐ NO
Fatigue or tire easily	☐ YES	☐ NO

RESPIRATORY:

Cough	☐ YES	☐ NO
Blood in sputum	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO

GASTROINTESTINAL:

Frequent heartburn/indigestion	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO
Constipation	☐ YES	☐ NO

ALLERGIC / IMMUNOLOGIC:

Hayfever	☐ YES	☐ NO
Hives	☐ YES	☐ NO
Immunodeficiency	☐ YES	☐ NO

KENNETH H FARRELL M.D. P.A.
PATIENT CONSENT FORM AND FINANCIAL POLICY

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

With my consent, KENNETH H. FARRELL M.D. P.A. (also referred to as "the Practice" within this form) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out 1) treatment, 2) payment and 3) healthcare operations (TPO). Please refer to the practices Notice of Privacy Practices for a more complete description of such uses and disclosures. I have had the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, KENNETH H. FARRELL M.D. P.A. may call or text my home, cellphone and/or other designated location and leave a message on voicemail, text message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, KENNETH H. FARRELL M.D. P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

MEDICAL INFORMATION CONTACT AND RELEASE PREFERENCES

I authorize KENNETH H. FARRELL MD PA to contact me regarding my health information using the following methods (check all that apply):			
Call Me	☐ at Home	☐ at Work	☐ on Cell
Leave Voicemail	☐ at Home	☐ at Work	☐ on Cell

I authorize KENNETH H. FARRELL MD PA to disclose my protected health information to the person(s) and/or organization(s) listed below (please leave blank if you do not wish to disclose your information):	
Individual / Organization Name	Relationship to Patient

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

CONSENT FOR TREATMENT:

Permission is hereby granted for employees or agents of KENNETH H. FARRELL M.D., P.A. (collectively, the "Provider") to render the patient named below such treatment as is deemed necessary within the Provider's Scope of Practice.

Signature	Date
Printed Name of Patient or Personal Representative	Relationship to Patient

(Continued on Next Page)

REFERRALS:

It is the patients responsibility to know if this is required by your insurance and, if so, to ensure that a valid referral is on file with our office. If you need a referral from your primary care physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your primary care physician and have your referral faxed to us.

COMMERCIAL INSURANCE:

As a courtesy, our billing office will file claims with all commercial insurance carriers that we are contracted with. If we are contracted with your insurance carrier then you are responsible for your share of the cost of service provided (as agreed to in the contract between you and your insurance policy). This may include co-pays, deductibles and/or co-insurance. In addition, some in-office diagnostic procedures may not be considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance.

MEDICARE PATIENTS:

We are participating with Medicare. We will bill Medicare for you. Please note, Federal Law requires us to collect your yearly deductible and co-insurance amounts (if applicable). If you have secondary insurance coverage we will bill your secondary insurance after Medicare pays.

SELF PAY PATIENTS:

Self-pay patients are responsible for paying for all services on the day of their office visit. We accept Visa, MasterCard, American Express, Discover, cash and check as forms of payment.

APPOINTMENT NO SHOWS:

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge a fee of $25 for any appointment that is not cancelled with proper notice.

DELINQUENT ACCOUNTS (COLLECTION POLICY):

If you have an outstanding balance after the time of your visit our billing office will send you a billing statement indicating the amount due. Payment of billing statements is expected within 30 days, statements unpaid after 30 days are considered delinquent. Delinquent accounts will be assigned to a collection agency and/or claims court after 90 days. If we have to refer your account to a collection agency, you agree to pay the past due amount in addition to collection costs of 20% (twenty percent) of the balance turned over.

RETURNED CHECK FEE:

There will be a $25 fee for any check that is returned for any reason (non-sufficient funds, etc).

I have read, understand and agree to the terms outlined in the above policies.	
Signature	Date
Printed Name of Patient or Personal Representative	Relationship to Patient