Gallery Medical

Date Completed

Patient Registration Form (Please fill in all fields completely)

Patient Information

Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Social Security Number
Other family members:			
Street Address (City, State, Zip Code)	Telephone #	Work #	Email Address:

Race : ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and other Pacific Islander ☐ White

Ethnic Group : ☐ Hispanic ☐ Non-Hispanic

Patient's Primary Language : English ____ Spanish ____ Other _____

Parent's/Legal Guardian's Primary Language : English ____ Spanish ____ Other _____

Does the parent/legal guardian require an interpreter? Yes ☐ No

If you have insurance, please present the insurance card to the check-in staff.

Emergency Contacts

Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			

Who may we thank for referring you to our practice?	

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #
Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Preferred Pharmacy		**Pharmacy Phone #**

Thank you for choosing Gallery Medical Family Clinic, Inc

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PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐Current ☐Past ☐Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐Current ☐Past ☐Never Drinks/week: _____

Recreational Drug Use: ☐Current ☐Past ☐Never Type: _____

Are you sexually active?

Are there any personal problems or concerns at home, work, or school you would like to discuss?

Are there any cultural or religious concerns you have related to our delivery of care?

Are there any financial issues that directly impact your ability to manage your health?

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

Gallery Medical

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren) and others involved in care as applicable.

☐ You have permission to leave information on my answering machine regarding my medical care and test results.

☐ You have my permission to speak with my spouse about my medical care.

☐ You have my permission to talk with my children or other family members involved with my medical care.

☐ Other, please describe _____

_____

_____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Gallery Medical

2020

FINANCIAL POLICY

We at Gallery Medical Family Clinic (Gallery) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your Gallery financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and NGP with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
NGP does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do _____ do not _____ currently have Medicaid insurance (Please Initial Response)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with a Gallery physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current card at each visit.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to Gallery or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- Gallery reserves the right to turn an account, over 90 days delinquent, to an outside agency for collection. This action will result in a fee, payable by the guarantor, of $50.00 or 50% of the outstanding balance, which ever is larger

Guarantor Signature: _____ Date:

Print Name: _____
Guarantor Date of Birth:
Relationship to Patient: _____

PATIENT(S) NAME: _____ Date of Birth: _____

Consent to Treat

Written Acknowledgement of Receipt of Gallery Medical Family Clinic, Inc Notice of Privacy Practices

_____
(Please initial)

I acknowledge receiving Gallery Medical Family Clinic, Inc (Gallery) Notice of Privacy Practices (The Notice). The Notice explains how Gallery may use and disclose your protected health information for treatment, payment and healthcare operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

If you have questions about the Notice, Please contact the Gallery Office. You may find their contact information located in the Notice.

General Consent to Treat

_____
(Please initial)

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Gallery Provider and his/her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____
(Please initial)

In agreement with federal and state law, I agree to allow Gallery to deliver the necessary care to this child in order to provide continuity of care and treatment. Gallery Medical Family Clinic or the patient's prov ider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard t o disclosures that have already been made in reliance on such consent.

_____
(Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Date _____

Thank you for choosing Gallery Medical Family Clinic, Inc

Acknowledgement of Privacy Practices

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By signing below, you acknowledge receiving the Gallery Medical Family Clinic, Inc (Gallery) Notice of Privacy Practices (Notice). The Notice explains how Gallery may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

Gallery reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at Gallery. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register at Gallery for healthcare services as a patient, Gallery will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.
If you have any questions about the Notice, please contact the Gallery Office. Contact information is located in the Notice.

Printed Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Date _____

Thank you for choosing Gallery Medical Family Clinic, Inc