Full Circle Women's Health LLP • Full Circle Midwifery LLC • Breastfeeding at Full Circle

Patient Registration Form

Patient Information

Please print clearly and complete all requested information for our electronic medical records.

Patient Full Name: ____ Date of Birth: ____________

Address: ________________________________City: ________________ State: _______ Zip: _________

Email: _________________ Home Phone ___________ Cell Phone _____________ Work Phone ________

Please check your preferred method of communication: ☐ *Email* ☐ *Home phone* ☐ *Cell* ☐ *Work phone*

Social Security #: ___________________ Marital Status: M S W D Separated Partner: M ____ F ____

Preferred Language: _________________ ☐Hispanic ☐Non-Hispanic

Check your Race: ☐African/African American ☐Asian/Asian American ☐Caucasian/European American ☐Hawaiian or other Pacific Islander ☐Native American or Alaskan ☐Other Race _____________________

Check Smoking Status: ☐Non-smoker ☐Previous smoker ☐Current smoker (packs/ day ____ x # years ____)

Current Medications/Supplements (please include dosage if you can): ☐None

____

Allergies to Medications, Environment or Food (please include reaction and severity) *(Ex. Penicillin, Rash-mild)*

☐None ____

Emergency Contact Information:

Contact Name: _______________________ Phone: ___________________ Relationship: ______________

How were you referred to Full Circle? ____

Insurance

Primary Insurance: ___________________ Member ID# _________Group # _______ Insured SSN: _________

Name of Insured: _____________________ Relationship to Patient: ____________ Insured DOB: ___________

Secondary Insurance: _________________ Member ID# _________ Group # _______ Insured SSN: _________

Name of Insured: _____________________ Relationship to Patient: ____________ Insured DOB: ___________

I hereby authorize Full Circle Women's Health/ Full Circle Integrative Care to release any medical information necessary to process any insurance claims and to apply for benefits on my behalf for covered services furnished to me by Full Circle Women's Health/ Full Circle Integrative Care. I certify that the insurance information supplied is correct and up to date and understand I will be responsible for any services not covered by insurance. I also understand that any co-payment or co-insurance is due at time of service.

Patients who have no insurance or are out-of-network with our insurance are considered to be self-pay patients, and payment will be expected at time of service. All lab work will be be billed separately by the laboratory and you are responsible for those charges as well. Your signature acknowledges that you have read this policy.

✔ Patient Signature: ____ Date: _____________

Access your Personal Health Records (PHR)

Obtain access to your lab results, appointment information, diagnoses and prescribed medications by giving us your email address and signature below. You will receive a PIN number from our office to use in a confirmation e-mail from Athena. Full Circle Women’s Health and Full Circle Integrative Care are participating in a national effort to expand the use of electronic medical records using a program called Athena. Take ownership of your healthcare by signing up today!

Email (please print): ______________________________ ✔ Signature: ______________________________

HIPAA Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given by you, your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I might contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

May we leave messages on your voice mail? Yes ____ No ____

Name and relationship of anyone authorized to have access to confidential medical records (e.g. spouse, parent, primary doctor):

Name: ______________________________ Relationship: ______________________________

In the event that I give you photographs of my baby and/or family members, I hereby consent to their display in your office hallway.

Patient Name: ______________________________ Date: ________________

✔ Signature: ______________________________

Appointment Cancellation Policy

We realize how busy you are and how appointments can be overlooked or forgotten. We set aside a significant amount of time for your appointment and we do not double book, so any “no show” or same-day cancellations create open hours in our schedule that could accommodate other patients waiting to be seen.

You will receive an appointment confirmation call 48 hours prior to your appointment. If we do not speak with you personally at that time, we require that you call us back at least 24 hours prior to your appointment to confirm. Our number is 914-421-1515 ext 0. If you are going out of town, feel free to call us to confirm anytime before you leave. If we do not hear from you, we will assume that you are unable to make the appointment and we will cancel it.

If you cancel, reschedule or “no show” on the day of your appointment, a $50 charge will be placed on your account, which you must pay before you can be seen again. Your signature acknowledges that you have read this policy. Thank you.

✔ Signature: ______________________________ Date: ________________