LOFTS MEDICAL ASSOCIATES, P.C.

New Patient Registration Form

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth	Gender

Address	Apt#	City	State	Zip Code

Social Security #	Preferred Language	Email

Home Phone	Cell Phone	Work Phone

Race:
___White ___Hispanic ___Asian ___Asian Indian ___Other
___Black/African American ___American Indian or Alaska Native
___Native Hawaiian or Other Pacific Islander ___Decline

Ethnicity: (Be Specific)
___Hispanic → What region?_____
___Not Hispanic
___Decline

PHARMACY INFORMATION

Pharmacy Name and Address

HIPPA APPROVED EMERGENCY CONTACTS

Name (First & Last)	Home Phone	Cell Phone	Relationship
Name (First & Last)	Home Phone	Cell Phone	Relationship

Acknowledgment of Receipt of Privacy Policy

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

With my consent, LOFTS MEDICAL ASSOCIATES, P.C. may use and disclose PHI about me to carry out treatment, payment and health care operations (TPO). Please refer to LOFTS MEDICAL ASSOCIATES, P.C. Notice of Privacy Policy for more complete description of such uses and disclosures.

With my consent LOFTS MEDICAL ASSOCIATES, P.C. 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.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out all TPO, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

Lofts Medical Associates participates in Secure Health Information Organization Network which makes it possible to share your Health Information electronically through a secure connected Network. You have the right to “opt-out” or decline to participate.

Additionally in signing, I also agree to allow access to my patient record by either eClinical Works or my insurance in the event that eClinical Works receives an audit request from the insurance or CMS.

By signing this form, I am consenting to LOFTS MEDICAL ASSOCIATES, P.C.'s use and disclosure of my PHI to carry out TPO, as well as sharing pertinent clinical information to referred specialty providers.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do no sign this consent, LOFTS MEDICAL ASSOCIATES, P.C. may decline to provide treatment.

Signature_____

Print Name_____ **Date**_____

Patient or Authorized Person's Signature

I, the undersigned, give my authorization to treat and assign directly to Lofts Medical Associates, P.C., all medical benefits, of any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that payment is expected at the time of service.

Signature_____ **Date**_____

May we leave a detailed message on your home phone? Y N May we leave a detailed message on your work phone? Y N

May we leave a detailed message on your cell phone? **Y N** **May we email you detailed messages?** **Y N**