



REGISTRATION/CONSENT FORM

(Please Print)

PATIENT INFORMATION					
Patient's Last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single Mar Div Sep Wid Other
AKA:					
Previous Last Name:	Social Security #:	Birth Date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:	City:	State:	Zip:		
PO Box:	E-Mail address: (For online Portal access)	Home phone #: ()	Cell phone #: ()		
Occupation:	Employer:	Employer Phone # ()			
Race:	Ethnicity:	Religion:	Language:		
Primary Physician:			Pharmacy:		

IN CASE OF EMERGENCY:	
Primary Contact:	Relationship to patient:
Home Phone #	Cell Phone #
Secondary Contact: (different address of patient)	Phone #:

GUARANTOR/ INSURANCE INFORMATION			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending (Medicaid Only)			
Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.			
Person responsible for bill (children under 19 only)	Birth date: / /	Address (if different):	Home phone no.: ()
Policy Holder Name		DOB :	SSN :
Occupation:	Employer:	Employer address:	Employer phone : ()
Patient's relationship to subscriber:	<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other



AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF QUALITY HEALTHCARE CLINIC, LLC ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HEREBY AUTHORIZE QUALITY HEALTHCARE CLINIC, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO QUALITY HEALTHCARE CLINIC, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE PROVIDER AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIES, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT:

I UNDERSTAND THAT QUALITY HEALTHCARE CLINIC, LLC. MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. QUALITY HEALTHCARE CLINIC MAY PROVIDE VACCINATION INFORMATION TO THE STATE VACCINE REGISTRY (NESIIS) VIA ELECTRONIC INTEGRATION.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES QUALITY HEALTHCARE CLINIC, LLC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW QUALITY HEALTHCARE CLINIC, LLC PRIVACY NOTICE, TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE. I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, QUALITY HEALTHCARE CLINIC, LLC MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT MY MEDICATION HISTORY WILL BE RETRIEVED FOR THE LAST 13 MONTHS INCLUDING MEDICATIONS I HAVE FILLED THROUGH MY PRESCRIPTION DRUG PLAN.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO QUALITY HEALTHCARE CLINIC, LLC

HIPPA ACKNOWLEDGEMENT: I HAVE RECEIVED AND HAVE READ THE MOST RECENT QUALITY HEALTHCARE CLINIC, LLC NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

(Please list authorized Representative (s) or mark N/A)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

Patient/Guardian signature

Date