PRIMARY CARE ASSOCIATES OF ERIE

PATIENT REGISTRATION FORM

PLEASE PRINT

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Patient Date of Birth: _____ Social Security #: _____

Any Previous Last Names: _____

Employer: _____

Email Address: _____ (required for Portal Access)

Patient Cell Phone Number: __(____ ___)_-_____-_____

Patient Home Phone Number: (____ ___)_-_____-_____

Patient Family Doctor: _____

Which method of contact would you prefer for appointment reminders?
We suggest choosing only one, but you may select multiple if desired.

____ E-mail
____ Text Message
____ Phone Call to Cell Phone
____ Phone Call to Home Phone

Note: If none of the above are selected, the contact method will default to a Phone call to your Home Phone if available.

Please check the identification group(s) that best applies to you. Check all that apply (optional):

Race

___ White ___ Black or African American ___ Asian ___ Other
___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander

Ethnicity

___ Hispanic or Latino ___Not Hispanic or Latino

Privacy Statement:

Your privacy is our utmost concern. In accordance with HIPAA regulation, we will keep your contact information private. This contact information will only be used by us to contact you for purposes pertaining to your medical care, such as appointment reminders, office announcements, and lab results.

PRIMARY CARE ASSOCIATES OF ERIE

PATIENT AUTHORIZATION FORM

1. RECEIPT OF NOTICE OF PRIVACY PRACTICES, WRITTEN ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received a copy of Primary Care Associates of Erie's Notice of Privacy Practices.

_____

PRINT NAME OF PATIENT DATE OF BIRTH DATE

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

_____

PERSONAL REPRESENTATIVE'S NAME RELATIONSHIP TO PATIENT

2. AUTHORIZATION TO RELEASE INFORMATION TO ANOTHER INDIVIDUAL (OPTIONAL)

I authorize Primary Care Associates of Erie to release information regarding my care and treatment to:

_____

PRINT NAME RELATIONSHIP PHONE NUMBER DATE

This consent is valid unless revoked by me in writing before the release of the designated information.

3. IN HOUSE TESTING

OB/GYN Associates of Erie performs in house testing including lab, sonograms, mammograms, and bone densities. The interpretations of our mammograms are billed through OB/GYN Associates of Erie and UPMC Hamot. Our biopsies and specialty labs are sent to Associated Clinical Laboratories (ACL) or LabCorp and they do the billing. If you would prefer to have your test done at another facility, please notify your provider.

4. INSURANCE AUTHORIZATION – PLEASE PRESENT CARD FOR SCANNING

I request that payment of authorized Medicare benefits be made either to me or on my behalf to OB/GYN ASSOCIATES OF ERIE, PC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the release of any medical information necessary to process insurance claims and request payment of insurance benefits to be made directly to OB/GYN ASSOCIATES OF ERIE, PC. I understand that I am financially responsible for all charges whether or not paid by said insurance.

5. TELEPHONE CONSUMER PROTECTION ACT (TCPA)

You agree that, in order for us to service your account or to collect monies you may owe, Primary Care Associates of Erie and/or its parent company, OB/GYN ASSOCIATES OF ERIE, PC, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Primary Care Associates of Erie and its parent company, OB/GYN ASSOCIATES OF ERIE, PC may contact me/us as described above.

_____

SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE DATE