Stephen A. Hickner, M.D.,LLC

Patient Registration

Name:_____ Date of Birth:_____

Social Security #:_____ Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Email Address: _____ Contact Preference:_____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

How You Heard About Us:_____

Guardian Name:_____

Emergency Contact Name:_____ Emergency Contact Relation:_____

Emergency Contact Phone:_____ Emergency Contact Cell Phone:_____

Primary Insurance Info

Policy Holder's Name:_____ Relationship to patient:_____

Policy Holder's DOB:_____ Policy Holder's SSN:_____

Insurance Name:_____ Phone:_____

Insurance Address:_____

Policy #:_____ Group #:_____

Secondary Insurance Info

Policy Holder's Name:_____ Relationship to patient:_____

Policy Holder's DOB:_____ Policy Holder's SSN:_____

Insurance Name:_____ Phone:_____

Insurance Address:_____

Policy #:_____ Group #:_____

Stephen A. Hickner, M.D.,LLC

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company or health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. Stephen A. Hickner, M.D., LLC has made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. Stephen A. Hickner, M.D., LLC will bill them, and I am required to pay a co-payment at the time of my visit. I understand that payment is due at the time of service. Stephen A. Hickner, M.D., LLC will file with up to two insurance companies. It is my responsibility as a patient to provide this office with current insurance information. I permit a copy of this authorization to be used in place of the original.

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable, including the administration of RhoGAM as indicated if I am Rh negative.

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the HIPAA Notice of Privacy Practices and I have been provided an opportunity to review it.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize Stephen A. Hickner, M.D., LLC to release any medical information, including confidential information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities.

AUTHORIZATION TO LEAVE MESSAGES IN MY ABSENCE: I hereby give Stephen A. Hickner, M.D., LLC permission to leave a general message on my answering machine or with the following people when I am unavailable. Leave information with: _____

I have read each of the statements above and authorize, understand and agree to each statement.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____

FOR PREGNANT PATIENTS

AUTHORIZATION FOR PRENATAL LABORATORY TESTING:

CBC (complete blood count)	Blood Type and Rh	Antibody Screen
Hepatitis B	Rubella	Serology (for Syphilis)
HIV (Human Immunodeficiency Virus)	Chlamydia Culture	Gonorrhea Culture
Pap Smear (if not done in past year)	Urinalysis	

I agree to have the routine prenatal labs: Yes:_____ No:_____

I agree to have the routine prenatal labs with the exception of: _____

Patient's Signature: _____ Date: _____