Triangle Family Care, P.A.

106-A Ridgeview Drive
Cary, NC 27511
(919) 319-6363

PATIENT REGISTRATION FORM

Patient Contact Information: Patient Chart Number _____

Last Name: _____ First Name: _____ M.I.: _____

Street Address _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Sex: M F Marital Status (circle): Single Married Widowed Divorced Separated Partnered

Driver's License #: _____ State Issued: _____ Country of Birth: _____

Home Phone: (_____) _____ Work Phone: (____) _____

Email: _____ Cell Phone: (_____) _____

Employer & Address: _____

Maiden name: _____ Spouse's/Partner's Name: _____

In Case of Emergency, Notify: _____ Daytime Phone: _____

Relationship to patient: _____

Insurance Policy Holder Information (if different than patient):

SS # _____ - _____ - _____ Date of Birth (mm/dd/yyyy) _____ / _____ / _____ Sex: _____

Last Name: _____ First Name: _____ M.I.: _____

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Employer Name & Address: _____

Relationship to Patient: _____

Medical Insurance Information (A copy of your insurance card is required at each visit)

PRIMARY Insurance Company Name: _____

Policyholder's Name: _____ Relationship to patient: _____

SECONDARY Insurance Company Name: _____

Policyholder's Name: _____ Relationship to patient: _____

PLEASE COMPLETE THE BACK OF THIS FORM.

Triangle Family Care, P.A.

Notice of Privacy Practices, Consent for Treatment and Authorization to Release Medical Information

Notice of Privacy Practices: The Notice of Privacy Practices is a complete description of the rights of patients at Triangle Family Care with respect to the patients' information and how that patient information is protected. This is posted in the lobby. I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. By signing below, I am stating that I have either reviewed or have received a copy of the Notice of Privacy Practices of Triangle Family Care.

Consent for Treatment/Care: By signing below, I consent to treatment/care as determined to be necessary by physicians and other healthcare providers at Triangle Family Care. I am aware that the practice of medicine and/or surgery is not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations or procedures.

Consent for Use and Release of Information: By signing below, I give permission to Triangle Family Care, treating physicians and other staff members to release any information about: me, my health, health services provided to me, and/or payment for health services which may be necessary for:

- Payment purposes, i.e. to file insurance claims for all services provided to you.
- Treatment purposes, i.e. to release protected health information to a referring physician.
- Healthcare operations, i.e. to release protected health information about you as necessary to process claims for payment for services provided to you, including to health and liability insurance companies; agencies processing Medicare, Medicaid, or worker's compensation claims; medical benefits plans, case managers or reviewers; or third parties responsible for paying claims for services provided to you.
- Notification of appointment reminders, notification of treatment alternatives, notification of health-related products, services and to send material such as holiday greeting cards, birthday cards, etc.

(Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information). This authorization and consent will remain in effect until rescinded or revoked in writing, except as disclosure is necessary after that date to process financial claims or is required or permitted by law. This authorization may be revoked at any time except to the extent that action based upon it has already been taken. I understand that this authorization covers services I may receive today or in the future. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at 919-319-6363, reading the notice in our lobby or, in the future by visiting our website at www.trianglefamilycare.com. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

Sharing Information with Family and Friends: I authorize Triangle Family Care to share with the people below, limited personal information 1) as it relates to my care or payment for my care, or 2) if needed to notify individuals about my location or general condition. Print names of people to whom we can release information:

_____

Or, if you **do not** want us to share information with any family member or friend, please initial here: _____

By signing this authorization and consent, I also authorize payment for those services provided to me to be made directly to the provider. I release Triangle Family Care, P.A., its employees, officers, agents and physicians from any legal liability for disclosure of information authorized herein. If I have questions about this authorization or, if I change my mind, I understand that I can call the office manager of Triangle Family Care, P.A. at 919-319-6363.

____ initials **Missed Appointment(s) Charge:** I understand that if I make, or someone on my behalf makes, an appointment and I miss that appointment, I will be charged $25.00 for each missed routine appointment and $50.00 for each missed physical appointment that is not cancelled within 24 hours prior to the appointment.

_____	_____	_____
(Patient/Responsible Party's Signature)	(Printed Name)	(Today's Date)
_____	_____	_____
(Patient/Responsible Party's Signature)	(Printed Name)	(Today's Date)

If Patient Representative signs: I confirm that I am legally authorized to speak on the patient's behalf regarding disclosure of information.

_____	_____	_____
(Representative's Signature/Relationship to Patient)	(Printed Name)	(Today's Date)