PATIENT REGISTRATION FORM

Patient Information*

First Name: ________________________________ **Middle Initial:** _______ **Last Name:** ______________________________

Date of Birth: ___________ **Social Security Number:** _____ - _____ - _____ **Gender (Circle):** MALE FEMALE OTHER

Address:________________________________ **Apt#**_______ **City:**_________________ **State:**_____ **Zip Code:** __________

County: ________ **Home Phone:**________________ **Work Phone:**_________________ **Cell Phone:**______________________

Email Address:____________________ **Preferred Method of Communication:** ☐ Phone ☐ Email ☐ Mail ☐ MyChart ☐ None

Primary Language:_______________________ **Interpreter Needed (Circle)?** YES NO **US Veteran (Circle)?** YES NO

Currently Homeless (Circle)? YES NO **At Risk for Homelessness (Circle)?** YES NO

Agricultural Seasonal/Migrant Worker (Circle)? Seasonal Migrant Neither **Ethnic Group (Circle):** Hispanic Non-Hispanic

Race (Circle): Native Alaskan Native Hawaiian Pacific Islander American Indian Asian Black White

Sexual Orientation (Circle): Straight Gay/Lesbian Bisexual Something Else Don't know Choose not to disclose

Marital Status (Circle): MARRIED SINGLE **Country of Origin**: _________________ **Primary Care Provider:** ______________

Employment and Income Information

Note: The income information (regardless of employment) is federally required for tracking purposes and is kept confidential

Household Annual Income: _____________________ **Family Size (Including Self):** _____________

IF EMPLOYED:

Occupation: _______________________________ **Hours per Week:**_______________ **Phone**____________________

Employer Name:________________________________ **Employment Status (Circle one):** Full time Part time Unemployed

Address:_____________________________________ **City:**_______________ **State:**_________ **Zip Code:** ___________

Guarantor: **Who is financially responsible for this Patient?** ☐ **Self** ☐ **Parent/Guardian ***

Emergency Contact: *FOR MINORS PLEASE PROVIDE THE PARENT/GUARDIAN INFORMATION HERE

Name: ________________________________ **Relationship to the Patient:** __________ **Legal Guardian (Circle)?** YES NO

Date of Birth: ___________ **Social Security Number:** ____-____-_____ **Gender (Circle):** MALE FEMALE **Other (Specify):**_______

Address:______________________________________ **City:**_______________ **State:**_________ **Zip Code:** __________

County: ____________ **Home Phone:**_________________ **Work Phone:**____________ **Cell Phone:**________________

Guarantor Primary Language: ___________________________

Insurance Information:

Primary Policy Holder Name: _________________ **Effective Date of Coverage:** _______________ **Date of Birth:** ___________

Coverage Name: _____________________ **Group Number:** _______________ **Subscriber Number:** _____________________

CONSENT FOR SERVICES

I am the patient or the parent/legal guardian/personal representative and I hereby give my consent to receive comprehensive medical health services at Axis Medical Center. I further authorize any health professional working for Axis Medical Center to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests done at the clinic and/or collected and performed by Quest Diagnostics, laboratory, imaging procedure done at clinic or performed offsite, medications, and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Axis Medical Center personnel under the instructions, orders or directions of the physician.

ASSIGNMENT OF INSURANCE BENEFITS

I am the patient or the parent/legal guardian/personal representative and I hereby assign and authorize payment of all my insurance benefits, Medicare benefits, and injury benefits due because of liability of a third-party, payable by any party or organization directly to Axis Medical Center and Lab and Imaging. If eligible for Medicare, I request payment of authorized Medicare benefits be made on my behalf for any services rendered and any holder of medical and other information about me to be released to Medicare agents that is needed to determine these benefits are for related services. I understand I am responsible for any charges not covered by my insurance company.

RELEASE OF INFORMATION

I am the patient or the parent/legal guardian/personal representative and I hereby give my consent to Axis Medical Center to release information of my health records for the purpose of processing and paying claims, coordination benefits, coordination treatment, coordinating care, research and quality assurance and improvement and other functions that support treatment, payment and health care operations, including those functions that my provider is required by my health plan, federal and state laws to perform.

STATEMENT OF FINANCIAL RESPONSIBILITY

I am the patient or the parent/legal guardian/personal representative and I acknowledge that I am financially responsible for all charges and services received at Axis Medical Center and Lab and Imaging. I understand I am obligated to pay in full (unless payment arrangements have been made) for any services received and if it becomes necessary to expedite collections of any amount owed and agree to pay for all costs and expenses, including reasonable attorney fees.

PATIENT REGISTRATION FORM

I am the patient or the parent/legal guardian/personal representative and I hereby certify that the information given on the patient registration form is true and correct to the best of my knowledge. I am knowledge that I am responsible for providing all accurate documentation required to support any discounts I may receive. I will inform Axis Medical Center of any changes to this form and provide updated documentation.

NOTICE OF PRIVACY PRACTICES

I am the patient or the parent/legal guardian/personal representative and I have fully read and understand the notice of privacy practices.

I am the patient or the parent/legal guardian/personal representative and I have fully read and understand the above information and give permission for the care as described.

Signature: **Relationship to Patient**: **Date:**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice or if you require more information, please contact our HIPAA Compliance Officer at the contact information listed at the end of this notice.

At AXIS, we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (PHI) and to give you this notice explaining our privacy practices with regard to that information. This notice explains your rights and our legal obligations regarding the privacy of your PHI.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearinghouse that relates to (1) your past, present, or future physical conditions; (2) the provision of health care to you; or (3) the past, present, or future payment for your health care.

AXIS is a participating member in an IHP (Integrated Health Partnership) that uses an HIE (Health Information Exchange) program and data warehouse. Your information will be stored and can be accessed by other facilities with your permission. If you don't want your information accessible please indicate your preference.

How We May Use and Disclose Your Protected Health Information

For your treatment: your PHI may be provided to a physician or healthcare provider (a specialist or laboratory) to whom you have been referred, to ensure they have the necessary information to diagnose, treat, or provide you a service.

For Payment: your PHI may be used and disclosed to enable us to bill and either collect payment from you, a health plan, or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree payment for that treatment.

For Health Care Operations: we may use and disclose your PHI in order to support the business activities of your physician's office. These activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, and the disclosure of information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Services: we may use and disclose your PHI to contact you to remind you that you have a scheduled appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.

As required by law: we will disclose your PHI when required to do so by international, federal, state, or local law.

Marketing and Selling of your PHI: these disclosures require your explicit written authorization.
Any Other Uses and Disclosures not recorded in this notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice had taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Regarding Your Protected Health Information

The Right to Inspect and Copy: Under federal law you have the right to inspect and copy your PHI (we have up to 30 days to make your PHI available to you; fees may apply). You have a right to a summary of your PHI instead of the entire record, or an explanation of the PHI which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request. However, if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fees may apply).

The Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your PHI and by law we must comply when the PHI pertains to solely to a health care item or service which the health care provider involved has been paid out of pocket in full. You also have the right to request a limit on the PHI we disclose about you to someone involved in your care or payment of your care. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

The Right to Request Amendments: If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer listed in the information at the end of this notice. In certain cases we may deny your request. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures pursuant to an authorization, for purposes of payment, treatment, healthcare operations; and as required by law, that which occurred six years prior to the date of request. Your request must be made in writing and you must indicate in what form you want the list, on paper or electronically. The first accounting of disclosures in any 12 month period will be free-of-charge. Any additional requests within that same time period may be subject to reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer listed at the end of this notice. Complaints must be submitted within 180 days of when you knew or suspected the violation. There will be no retaliation against you for filing a complaint.
To file a complaint with the Secretary, mail your complaint to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington D.C. 20201. Or call (202) 696-6775 or go to the website of the Office for Civil Rights www.hhs.gov/ocr/hippa for more information. There will be no retaliation against you for filing a complaint.

If you have any questions in reference to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at the address at the end of this notice. You have the right to request a paper copy of this notice at any time if you have agreed to receive this notice electronically. Please acknowledge that you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

AXIS Medical Center
1801 Nicollet Avenue S
Minneapolis, MN 55403
HIPAA Compliance Officer
PH 612-823-2947