FMC Family Medical Center
A Service of
HMH HARDIN MEMORIAL HEALTH

Patient Registration Information

Patient's Personal Information
Please PRINT AND complete ALL sections below!

NAME: *Last* *First* *Middle* | **Date of Birth:** / / | **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | **Social Security Number:** - -

Address: **Apt. #:** **City:** **Zip Code:**

Home Phone: ( ) - **Cell Phone:** ( ) - **Work Phone:** ( ) -

E-Mail Address: | **Employed:** ☐ Full Time ☐ Part Time **or** ☐ Student FT

Employer: **Phone** ( ) - **Address:**

Spouse's Name: | **SSN:** | **DOB:** - - | **Employer:**

Is Visit related to an Automobile Accident? ☐ Yes ☐ No **or** **Workers Comp Claim?** ☐ Yes ☐ No

Date of Injury: ________________________ *****Provide Auto Insurance / Workman's Compensation Information*****

Responsible Party if Patient is a Minor
Complete page 3

Name: **Relationship:**

Patient's Insurance Information
***Please present insurance cards or other information to receptionist. ***

PRIMARY Insurance: | **Insured's Name:** | **Date of Birth:** / /

Policy / ID#: | **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other:

Group #: | **Claims Address:**

SECONDARY Insurance: | **Insured's Name:** | **Date of Birth:** / /

Policy / ID#: | **Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other:

Group #: | **Claims Address:**

Emergency Contact
***Someone not living in the same home. ***

Name: **Relationship:**

Home Phone: ( ) - **Cell Phone:** ( ) - **Work Phone:** ( ) -

Address: **Apt. #:** **City:** **Zip Code:**

Do you have a Living Will? ☐ Yes ☐ No **Do you have an Advanced Directive?** ☐ Yes ☐ No

******If YES, Please provide copies for your chart******

AUTHORIZATION • ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT I hereby authorize the release of any medical information for the treatment, payment and healthcare operations. I assign the benefits payable for physician services to Family Medical Center. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account. I understand that if for any reason my account should be sent to a collection agency, I may be responsible for that collection agency fee and until my accounts are finally settled, I give my direct consent to receive communications regarding my account from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline or text number I provide, 2) any e-mail address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications. I further agree that a photocopy of this agreement shall be as valid as the original.

√ ____ ____________________

Patient or Guardian Signature **Date**

Also, the event that I cannot be reached by phone, I authorize BPC/FMC to leave a message with a family member, or on my answering machine. I understand and accept this consent.

√ ____ ____________________

Patient or Guardian Signature **Date**

Consent refused by patient and witnessed by: ______________________ & ______________________

(For Office Use Only)
Consent received by: ____________________ Date: __________
Added to Medical Record by: ____________________ Date: __________

COMPLETE REVERSE

RECEIPT OF NOTICE of PRIVACY PRACTICES

I, ____, have received a copy of FMC's Notice of Privacy Practices.

√ ____ ____________________

Patient or Guardian Signature **Date**

FORMULARY BENEFITS DATA CONSENT

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Family Medical Center to access my pharmacy benefits data electronically through RxHub. This consent will enable Family Medical Center to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

√ ____ ____________________

Printed Name **Date of Birth**

√ ____ ____________________

Patient or Guardian Signature **Date**

Preferred Lab:

Some insurance companies require that your labs be sent to a specific company for processing. If your insurance company prefers a specific lab, please select below your preferred lab:

☐ Hardin Memorial Health ☐ LabCorp ☐ Quest Diagnostic

NOTE: All labs will be processed by Hardin Memorial Health under the following circumstances:

1. Labs that our physician needs immediate results
2. Patients with Passport Health Plan or Kentucky Medicaid
3. If you do not select a preferred lab below

√ ____ ____________________

Patient or Guardian Signature **Date**

******Please be advised if your insurance changes, it is your responsibility to notify us of the change******

If PATIENT is a MINOR CHILD provide the following information:

FATHER's Information:	
Name:	
Social Security #:	
Date of Birth:	
Address:	
Home Phone:	
Cell Phone:	
Work Phone:	
Employer:	
Employer Address:	

MOTHER's Information:	
Name:	
Social Security #:	
Date of Birth:	
Address:	
Home Phone:	
Cell Phone:	
Work Phone:	
Employer:	
Employer Address:	