Ventana Medical Group – Evergreen

2365 Quimby Road Suite 260
San Jose, CA 95122
Phone: 408-708-9988 Fax: 408-274-2038

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS:

First Name: _____ Middle: _____ Last Name: _____

Marital Status: Single ☐Married ☐ Divorce ☐ Widowed ☐ Sex: Male ☐ Female ☐

Social Security# _____ DOB: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work #: _____ E-Mail_____

Home Phone: _____

LANGUAGE, ETHNICITY, RACE:

Language You Prefer To Use: ☐ENGLISH ☐SPANISH ☐VIETNAMESE ☐PUNJABI OTHER: _____

☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North or South America (including Central America), and who maintains a tribal affiliation or community attachment.

☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.

☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless or race

DO YOU HAVE INSURANCE? ☐ YES ☐ NO

INSURANCE INFORMATION /NAME OF PRIMARY INSURER:

First Name: _____ Last Name: _____

DOB: _____ Social Security #_____ Relationship: _____

Home Phone #: _____ Work #: _____ Mobile #: _____

Primary Insurance: _____

Secondary Insurance: _____

EMERGENCY CONTACT

Emergency Name: _____ Relationship: _____

Emergency Phone #: _____

I understand that my COPAY due at the time of service.
I understand that you will charge my visit cost to my credit card if I do not provide current insurance information within 48 hours.
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Ventana] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but or not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: required Uses and Disclosures: Under the law, we must make disclosures to you and when required by Secretary of the Department of Health and human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will by be made only with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or us in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protection health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You the have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If w deny your request for amendment, 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 of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, it any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that you have received this **Notice of Privacy Practices:**

_____ _____

NAME DATE

_____

SIGNATURE