



New Patient Registration | Updated Contact Information

Legal Name:		Preferred Name:	Date:
Street Address:			
City:	State:	Zip:	
Date of Birth:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		Secondary Phone Number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	
Email:		Social Security Number:	
Emergency Contact:		Emergency Contact Phone Number:	
Emergency Contact Relation:		May we discuss medical information with this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Pharmacy Name:		Location/Intersection:	
Which category best describes your race? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hawaiian or other Pacific Islander <input type="checkbox"/> Asian (includes Pakistan or Indian origins) <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____ Do you consider yourself Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline What is your primary language? _____			
How did you hear about Driven Health? (check all that apply) <input type="checkbox"/> Established Patient <input type="checkbox"/> Drive By <input type="checkbox"/> Internet <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Facebook <input type="checkbox"/> ZocDoc <input type="checkbox"/> Advertisement <input type="checkbox"/> ER/Hospital/Urgent Care: _____ <input type="checkbox"/> Insurance Company <input type="checkbox"/> Mail <input type="checkbox"/> My Doctor: _____ <input type="checkbox"/> Other: _____			

Complete this section only if patient is a minor or the guarantor is someone other than the patient.

Name:		Relationship to Patient:	
Mailing Address:		City:	State: Zip:
Primary Phone Number:		Secondary Phone Number:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security Number:	

Primary Insurance Company:		Policy ID:	Group #:
Subscriber Name:		Relationship to Patient:	
Subscriber Date of Birth:		Subscriber SSN:	

Secondary Insurance Company:		Policy ID:	Group #:
Subscriber Name:		Relationship to Patient:	
Subscriber Date of Birth:		Subscriber SSN:	

Patient Name

DOB

_____**Consent for Treatment and Payment Agreement:** I consent to Driven Health's administration and performance of general treatment, use of prescribed medications, performance of diagnostic procedures, tests and cultures, and performance of other laboratory tests that my physician or his designee determines medically necessary or advisable based on the judgment of my physician or their assigned designees. I give this consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. I understand that my consent on this form extends to practice locations affiliated with Driven Health. A photocopy of this consent shall be as valid as the original. I understand that while my consent is voluntary, if I refuse to sign this consent, Driven Health may refuse to treat me.

_____**Minor/Disabled Patient:** If I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Driven Health that I have the legal authority to consent to treatment on the patient's behalf and that I do in fact consent to treatment as described in the preceding paragraph. In such a case, references in this form to "I", "me", or "my" are intended as references to the patient where appropriate in the context.

_____**Exposure Testing:** I understand that in the case of an accidental exposure to blood or other bodily fluids, state law allows Driven Health to perform an HIV test without obtaining the patient's consent on a patient who may have exposed a healthcare worker to HIV.

_____**Patient Responsibility for Follow-Up:** I understand that it is my responsibility to follow any discharge and/or follow-up instructions Driven Health may provide to me, including without limitation any recommended home-care and any follow-up examination and/or treatment by other healthcare providers. I accept full responsibility for the consequences of any failure by me to obtain recommended follow-up care and/or to comply with any other discharge instructions related to this Driven Health visit.

_____**Responsibility for Payment:** In consideration of the services Driven Health will provide to me, I promise to pay Driven Health's charges for such services. I understand Driven Health may file its bill with my insurance company, but I understand that it is my responsibility to obtain any referral forms from my primary care physician that my insurance company may require as a condition to its payment for my healthcare service. I understand that the cost of healthcare services provided to me is my personal responsibility, even if I have insurance coverage for that cost, and that I am directly liable to Driven Health for any portion of such cost that my insurance company or other third-party payer does not pay, for any reason. If I am signing this form on behalf of a person whom I have allowed to be a dependent on my insurance coverage, I acknowledge that I am personally liable for any copayment, deductible obligation, or other portion of Driven Health's charge for services to that person that my insurance company or other third-party payer does not pay. If the patient is my minor child, I acknowledge that I am legally responsible to Driven Health for its charges for services to the patient without regard to the allocation of liability for such charges as between other persons and me in a decree of divorce or other court order or decree. I understand that if my account with Driven Health is unpaid for more than a reasonable amount of time Driven Health will place my account with a collection agency, and, if necessary, cause my unpaid account to appear on my credit report. I agree to endorse and forward to Driven Health all insurance or third-party payments that I receive for services Driven Health has rendered to me, immediately upon my receipt of such payments.

_____**Medical Records:** I understand that Driven Health maintains medical records in the office which will be used on an ongoing basis for planning care and treatment. Information within the medical record may be released by Driven Health to my other physicians/healthcare providers and insurance company as necessary for billing and medical reasons. I authorize Driven Health to access by prescription history from external sources. **MEDICARE PATIENTS:** I authorize Driven Health to release my medical information to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for services to Driven Health.

_____**Email:** If I have provided my email address on this form I understand that Driven Health will keep that address confidential and will not rent or sell it. I understand that Driven Health has requested my email address in case Driven Health needs to contact me. I consent to Driven Health's sending me, as a courtesy, 48-hour patient follow-up communications, satisfaction surveys, or urgent notices. I consent to Driven Health sending unsecured emails regarding my Driven Health visit to the email address I have provided on this form.

_____**Consent to Wireless Telephone Calls:** I consent to receive telephone calls and other communications on my cellular phone, other phone(s), and other communications devices, including autodialed calls and prerecorded messages from Driven Health, its successors, assigns, affiliates, agents, independent contractors, servicers, and collection agents. I understand these calls may regard my visit to Driven Health or financial obligations related to my visit.

_____**Consent to Access Prescription History from External Pharmacy Sources:** I understand that it might be beneficial for the providers at Driven Health to access my medication history from various pharmacies. This information will be used for my care through Driven Health and will not be shared with external organizations.

**I acknowledge that I have received or been given the opportunity to receive a copy of Driven Health's HIPAA Privacy Policy and understand that if I have any questions or complaints, I should contact the Driven Health's Privacy Officer at 214.285.0041

* _____ (Patient/Guardian Initials)

Signature of Patient, Parent, or Legal Guardian

Date