New Patient Registration | Updated Contact Information

Legal Name:	**Preferred Name:**	**Date:**
Street Address:		
City:	**State:**	**Zip:**
Date of Birth:	**Age:**	**Gender:** ☐ Male ☐ Female
Primary Phone Number: ☐ Cell ☐ Home ☐ Work	**Secondary Phone Number:** ☐ Cell ☐ Home ☐ Work	
Email:	**Social Security Number:**	
Emergency Contact:	**Emergency Contact Phone Number:**	
Emergency Contact Relation:	**May we discuss medical information with this contact?** ☐ Yes ☐ No	
Preferred Pharmacy Name:	**Location/Intersection:**	

Which category best describes your race? ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Hawaiian or other Pacific Islander ☐ Asian (includes Pakistan or Indian origins) ☐ Hispanic ☐ Other:_____

Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline

What is your primary language? _____

How did you hear about Driven Health? (check all that apply) ☐ Established Patient ☐ Drive By ☐ Internet ☐ Friend/Relative ☐ Facebook ☐ ZocDoc ☐ Advertisement ☐ ER/Hospital/Urgent Care: _____ ☐ Insurance Company ☐ Mail ☐ My Doctor: _____ ☐ 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: ☐ Male ☐ 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:**	

_____ / _____

My preferred method of communication regarding my **medical condition(s)** is indicated below **(check one):**

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Mailed Letter ☐ Guardian ☐ Secure Email ☐ Patient Portal

If the above method of communication is by phone, please check the appropriate box below **(check one):**

☐ Leave a message with detailed information. ☐ Leave a message with a call-back number only.

Please note that you are responsible for any charged incurred in receiving our communications. Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be contacted at all.

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **BILLING ACCOUNT** and **MEDICAL CONDTION(S)** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that Driven Health is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list.

_____ _____ _____

Contact Name Relationship to Patient Phone Number

☐ Billing Account Information ☐ Medical Condition Information

_____ _____ _____

Contact Name Relationship to Patient Phone Number

☐ Billing Account Information ☐ Medical Condition Information

There may be times when you need a friend or family member to pick-up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the prescription, your designee will need to present valid picture identification and sign for the prescription.

_____(Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____Date:_____

Name: _____Date:_____

<u>Please list any specialists/doctors or other medical health providers that care for you.</u>

(examples: cardiologist, physical therapy)

Name:	City:
Name:	City:
Name:	City:
Name:	City:
Name:	City:

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

_____ _____

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**