Starling PHYSICIANS
Healthcare the way it should be

2018 PATIENT REGISTRATION FORM

First Name: _____ **Last Name**: _____ **M.I.**: _____

Date of Birth: _____ **Social Security #**: _____

HIPAA Disclosure Information: With whom do you allow us to share your personal medical information?

Name of Disclosee	Relationship to Patient	Phone Number	Share Non-Clinical* Info	Share Clinical Info
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

* Non-Clinical info would be scheduled/appointment information only.

Signature: _____ **Date**: _____

With my signature, I am confirming that the information above is correct to the best of my knowledge. I also acknowledge that it is my responsibility to alert Starling of any changes to my HIPAA information.

Patient Demographics

Gender: Female ☐ Male ☐ | **Primary Language**: _____ | **Marital Status (S/M/W/D)**: _____

Race (check one): Black/African American ☐ Asian ☐ White ☐ American Indian ☐ Declined ☐ Other ☐_____

Ethnicity (check one): Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined ☐ |**Advance Directive/Living Will**: Yes ☐ No ☐

Mailing Address: _____

APT/Unit: _____ | **City, State, Zip**: _____ | **Minor** *(if under 18)*: ☐

Phone: _____ **May we leave a message regarding your medical care or test results?** Yes ☐ No ☐

Employer (Name, Address): _____ **Employer Phone**: ( )_____

Insurance Information

Primary| **Company Name**: _____

Policy #: _____ | **Group #**:_____

Primary Subscriber| **Name**: _____

D.O.B.: _____ | **Relationship**: _____

Secondary| **Company Name**: _____

Policy #: _____ | **Group #**:_____

Secondary Subscriber| **Name**: _____

D.O.B.: _____ | **Relationship**: _____

Additional Information

Primary Care Physician (Name): _____ **Phone**: ( )_____

Address (PCP): _____ **Referring Provider** (Name): _____

Address (Referring Provider): _____ **Check here if Self-Referred**: ☐

Emergency Contact Information: Who can we call in case of an emergency?

Emergency Contact Name	Relationship	Phone Number	Leave Message	Message Type
			Yes ☐ No ☐	Detailed ☐ Brief ☐

PLEASE TURN PAGE OVER

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Appointment Confirmation

Please note: As a service to our patients, Starling Physicians, P.C. uses an automated confirmation service to remind you of your appointment. In the event the call is not answered, a message is left.

Check a single method of automated confirmation and enter the necessary info on the adjacent line:

☐ Call (Home/Cell*) _____

☐ Email _____

☐ Text*_____

☐ I would prefer **not** to have an automated reminder.

☐ I already receive reminders via Follow My Health.

*Indicating in the affirmative that this is your preferred method of contact acknowledges that you are aware of and will accept any usage charges that may apply from your cell phone carrier.

Authorization and Release

I hereby authorize payment directly to Starling Physicians, P.C. of medical benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this assignment. I hereby authorize Starling Physicians, P.C. to release information requested to support my claim.

Signature: _____ **Date**: _____

For Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to Starling Physicians, P.C. for any service provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Signature: _____ **Date**:_____

Missed Appointment Policy

Please be advised that Starling Physicians, P.C. reserves the right to charge for missed appointments. If you do not keep your appointment and have not called to cancel or reschedule 24 hours prior to the scheduled appointment, a charge may be applied to your account.

Payment and Patient Responsibility Policy

Please be advised that, under your insurance contract, you are responsible for your co-payment, co-insurance or deductible. It is the policy of Starling Physicians, P.C. to collect all co-payments due at the time of service. Additionally, it will be requested that you pay any outstanding, open balances at the time of service.

By signing, you acknowledge that you have been informed of and agree to the terms of these policies.

Signature: _____ **Date**:_____

***We would like to receive your feedback, regarding your visits to Starling. Please provide your email address below if you would like to share your experiences, regarding our services, in the form of a patient survey:**

Email:_____ **Date**: _____