PATIENT REGISTRATION – PLEASE PRINT AND COMPLETE ALL ENTRIES

LAST NAME: _____ FIRST NAME: _____ M.I _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ DATE OF BIRTH: _____ SSN: _____

SEX: □MALE □FEMALE □ OTHER _____ EMAIL: _____

WOULD YOU LIKE TO BE WEB ENABLED? □YES □NO EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

INSURED/RESPONSIBLE PARTY NAME: _____ □ SPOUSE □ PARENT □ GUARDIAN

DATE OF BIRTH: _____ PHONE: _____ SSN: _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE DOCTOR/PEDIATRICIAN: _____PHARMACY: _____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The information to be covered by this authorization includes: Printed, digital and verbal protected health information. Persons who can use this information: Pulse Urgent Care, Docs Medical Group, Inc., their associates, and staff. Additional persons we are authorized to disclose private health information:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

This authorization will remain in effect until ____/____/_____ or one year from signature date, unless otherwise revoked or terminated by the patient, parent, legal guardian, or legal representative. You may revoke or terminate this authorization by submitting in writing to Pulse Urgent Care. You can also contact the office manager or records department to terminate this authorization. **Potential for re-disclosure:** For the safety and protection of your protected health information please be aware that under this authorization any information that is obtained by the above may be disclosed again by the person or organization to which it is sent. The privacy of the release of information may not be protected under the federal regulations.

Signature of Patient, Parent, Legal Guardian _____ **DATE:** _____

Print Name: _____ **Relationship:** _____

I acknowledge that I have been informed that the Notice of Privacy Practices for Docs Medical Group, Inc. dba Pulse Urgent Care is posted in the lobby and available for review at any time. I understand that a printed copy of the Notice of Privacy Practices is available to me upon request. The Notice of Privacy Practices explains how my medical information may be used and disclosed and describes my rights regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing below, I acknowledge that I have been made aware of the availability of the Notice of Privacy Practices.

Signature of Patient, Parent, Legal Guardian _____ **DATE:** _____

Print Name: _____ **Relationship:** _____