**REASON FOR VISIT:** 

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEW PATIENT REGISTRATION FORM**

# Patient Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_

SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (include Apt #): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City / State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (write clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By providing my email, I consent to receive medical records, billing statements and be contacted via email.**

**Emergency Contact Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By providing emergency contact information, I give authorization to contact this number/email and disclose any relevant protected health information.**

# Primary Insurance Information

| Insurance Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- | --- |
| Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ | Policy Holder DOB : \_\_\_\_\_\_\_\_\_\_\_\_ |
| Policy or Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Secondary Insurance Information** | Group # (if plan has one): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insurance Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ | Policy Holder DOB : \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

**Pharmacy Info: (Prescriptions sent here; changing address post-visit *may delay by 48 hours.*)**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quick Health History

| Allergies | Reaction |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Current Medications and Daily Supplements | |  |  |
| Medication Name | Dosage | How Often | Reason for Medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TURN PAGE OVER**

**Consent to Medical Treatment:** I voluntarily present for treatment and consent to treatment by an ApproXie health care provider. Such care may include, but is not limited to: diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that my treatment is intended to address a specific episodic illness or injury and is not intended as a substitute for a primary care physician or other specialized physician, and that no guarantee can be made or has been made as to the results of treatments or examinations at ApproXie. **Initials: \_\_\_\_\_\_\_\_\_\_**

**Notice of Privacy Practices:** I acknowledge review of ApproXie Health's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights. **Initials:\_\_\_\_\_\_\_\_\_\_\_**

## Payment Policy

## It is ApproXie’s policy to collect any copayments and coinsurance payments at the time of any provided service. I allow ApproXie to file insurance claims on my behalf, and I understand that I’m responsible for any unpaid balance. I agree to pay all fees, including collection and legal costs if required (33.3%). I give up any rights to exemption under Alabama or other state laws and agree to be contacted by phone, text, or email, including automated messages or calls in regards to my account. I understand that I am responsible for paying all costs associated with any testing or fees that are not covered by my insurance. This includes but is not limited to deductibles, copayments, coinsurance, and any other out-of-pocket expenses.

Due to rising costs and fixed healthcare fees, a 2.9% + $0.30 processing fee will apply to all credit card transactions, excluding HSA/FSA cards. Our front desk team is available for any questions.

If your insurance deductible exceeds $175 and has not been met, a $75 fee will be collected at the time of service. Once your insurance processes the claim, any overpayment will be refunded to the original payment method.

**Patients will be responsible for paying all costs associated with any testing or fees (e.g PCR, after-hours) that are not covered by their insurance. This includes but is not limited to deductibles, co-payments, co-insurance, and any other out-of-pocket expenses.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Card on File Consent (Optional)**

As part of our commitment to providing you with the best possible care and convenience, we offer the option to keep your credit or debit card on file. This policy enables quicker payments for your visits and ensures a smooth billing process.

**Consent to Card on File:** By consenting to this policy, you agree to allow us to securely store your credit or debit card information for future payments.

**Outstanding Balances:** In the event that you have an outstanding balance, we will make two attempts to contact you regarding the payment. If we are unable to reach you after these attempts, you authorize us to charge the card on file to settle any outstanding balance.

Your payment information will be stored securely and used only for the purposes outlined above.

Please indicate your consent below:

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email insurance card(s) to support@approxie.com if you do not have physical cards.**