El Paso Pulmonary Association - Patient Registration Form

Welcome! - In order to access the services of our practice, we ask that this form is completely filled out and signed.

*Last Name:	*First Name:	MI	*Date of Birth:	***Primary doctor (PCP):**	
Street Address:			Sex:	**Referring doctor:**	
*City:	*State:	*Zip	Age:	Cell phone #:	Home#:
SSN:	Marital status:	(Optional) Race: Ethicity:		Email address (to set up your patient portal access):	
Mailing address if different from above:	City:	State:	Zip:	Preferred Method of Contact: [ ] Cell phone /voice message [ ] Text [ ] Home phone [ ] Patient Portal	
Emergency Contact Name:		Preferred language: [ ]English [ ]Spanish		We use messenger calling to remind patients of appointments. What time would be best to contact you?:	[ ] 9:00AM [ ] 1:00PM [ ] 6:00PM
Relationship:	Phone:				
Preferred Pharmacy Name:			Address:		Phone:

1 With your authorization, we can have access to your external prescription history as stored in the Prescription (Rx) Data Hub. Information may include history from several years back on prescriptions from other medical providers, prescriptions. This access might facilitate your care and treatment.

[ ] I athorize access

[ ] I don't athorize access

INSURANCE INFORMATION: ***Please allow us a copy your ID card(s).***		Other Insured's DOB:	**Insured**	
Insured's Name (if other than self):		Relationship to patient:	**Self**	**Other**
Primary Insurance:	Co-pay:$	Subscriber ID#:	[ ]	[ ]
Secondary Insurance:	Co-pay:$	Subscriber ID#:	[ ]	[ ]

Please read carefully and acknowledge. Your signature below is an acknowledgement of understanding and authorization.

CONSENT FOR TREATMENT and DISCLOSURE OF INFORMATION

2 * I hereby request and authorize medical care and treatment from El Paso Pulmonary Association and its associates.

3 * I understand that if I bring a companion or companions, friend(s) or relative(s) into this office, I am giving my permission to all physicians, employees and associates at El Paso Pulmonary Association to discuss my treatment and information with me and possibly such companion(s) as they will be present during visit. ***If you do not wish for information to be discussed in front of your companion, please ask them not to come into the exam room or clinic area and to wait for you in the lobby.***

4 * I authorize El Paso Pulmonary Association/partners and associates, to share/obtain/release copies of my medical records to any entity, physician or institution for the purpose of my evaluation or treatment as per HIPAA rules including the participation in PHIX and Elligo Health Research as indicated in the Notice of Privacy Policies of El Paso Pulmonary Association, which is posted in the waiting area of this office and of which a copy has been made available to me. ***Please read our Notice of Privacy Practices and take a copy .***

MESSAGES AND COMMUNICATION

5 **Authorization to call/text or email you and or your authorized individual**: In the course of business, we might need to contact you regarding your appointments, results, treatment, prescriptions, medical information, and account information by the method of contact provided. Messages may be left by either answering machine, voice mail, text message, portal account or with any authorized individual(s) listed below.

□ I **authorize only** reminders to be left with anyone at my preferred phone number or method above.

□ I authorize information to be shared with the following individuals:

Name(s)	Relationship:	Phone:

□ I **DO NOT** authorize the release of any information to anyone other than myself. I acknowledge that by choosing this option, all reminders from El Paso Pulmonary Association will be **DISABLED (you will not receive appointment reminders), and I further acknowledge that no one will be able to call on my behalf to obtain or give information in regards to my appointments, prescriptions, account or other matters.**

"With my signature below, I confirm that I have read all the information and that I give all 5 authorizations above. Further, I confirm that all the information that I have provided is true and current to the best of my knowledge".

Patient/Guardian Signature: X	**If guardian, print name & relationship:**	**Date:**