1774 Metromedical Drive, Fayetteville, NC 28304-3861 Phone: (910) 568-3903 Fax: (910) 568-3908

REGISTRATION FORM

(Please Print)

Today's date: _______________ Primary Care Provider: __________________________ Phone: _________________

Pharmacy Name: ____ Pharmacy Phone: ____________________________

Pharmacy Address: ____
STREET CITY STATE ZIP CODE

PATIENT INFORMATION

Last Name: _______________________________ **First Name:** ______________________________ **MI:** _________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Date of Birth** (mm/dd/yyyy): _________________

Social Security #: ________________________ **Gender:** ☐ Male ☐ Female ☐ Transgender **Race:** ________________

Mailing address: ____
STREET CITY STATE ZIP CODE

Home Phone: ____________________ **Cell Phone:** _____________________ **Email address:** __________________________

Employment Status: ☐ Full Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Student

Employer Name: _____________________________________ **Employer Phone:** ______________________________

May we leave a message on your home phone? ☐ Yes ☐ No May we leave a message on your cell phone? ☐ Yes ☐ No

May we send text reminders for appointments? ☐ Yes ☐ No May we send email reminders for appointments? ☐ Yes ☐ No

Please list family members with whom we may discuss test results:

Name: _______________________________________ Relationship: _______________ Phone: _____________________

Name: _______________________________________ Relationship: _______________ Phone: _____________________

EMERGENCY CONTACT

Name: _______________________________________ Relationship: _______________ Phone: _____________________

Name: _______________________________________ Relationship: _______________ Phone: _____________________

Do you live in a long-term care facility? ☐ No ☐ Yes **Room:** ____________ **Phone:** ________________________

Name of Facility: ____ **Case Manager:** ____________________________

Mailing address: ____
STREET CITY STATE ZIP CODE

Carolina Infectious Disease PA

1774 Metromedical Drive, Fayetteville, NC 28304-3861 Phone: (910) 568-3903 Fax: (910) 568-3908

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ☐ Yes ☐ No

- Primary Insurance Name: ______________________ Policy ID#: ________________ Group ID#: __________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________

★ If different than patient:

★ **Last Name:** ________________________ **First Name:** _________________________ **MI:** _____

★ **Mailing address:** ____

STREET CITY STATE ZIP CODE

★ **Subscriber's Social Security #:** __________________ **Subscriber's Date of Birth** (mm/dd/yyyy): ________________

- Secondary Insurance Name: ______________________ Policy ID#: ________________ Group ID#: __________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________

★ If different than patient:

★ **Last Name:** ________________________ **First Name:** _________________________ **MI:** _____

★ **Mailing address:** ____

STREET CITY STATE ZIP CODE

★ **Subscriber's Social Security #:** __________________ **Subscriber's Date of Birth** (mm/dd/yyyy): ________________

POWER OF ATTORNEY

Do you have a Power of Attorney? ☐ No ☐ Yes If yes, please provide the following information:

Name of Power of Attorney: ______________________________ **Relationship to Patient:** ________________

Mailing address: ____

STREET CITY STATE ZIP CODE

Home Phone: __________________ **Cell Phone:** __________________ **Email address:** ______________________

1774 Metromedical Drive, Fayetteville, NC 28304-3861 Phone: (910) 568-3903 Fax: (910) 568-3908

Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, medical services, and diagnostic procedures (including but not limited to the use of lab studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. **VALUABLES:** Carolina Infectious Disease assumes no responsibility for, and I hereby release Carolina Infectious Disease from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.
2. **SCHEDULED APPOINTMENTS:** If I am ***15 minutes*** past my scheduled time, Carolina Infectious Disease has the right to reschedule my appointment.
3. **APPOINTMENT REMINDERS:** I agree to appointment reminders by phone, text message and e-mail. Any fees incurred by this action, will be my sole responsibility.
4. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS:** I hereby expressly authorize Carolina Infectious Disease and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payer) which may be responsible for paying for my care. I authorize and direct all payers to pay all benefits due for such care directly to Carolina Infectious Disease and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Carolina Infectious Disease and the third-party payer signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
5. **PAYMENT FOR SERVICES:** In return for services to be provided by Carolina Infectious Disease, I promise to pay for services rendered by Carolina Infectious Disease to me for my benefit. If the services I receive from Carolina Infectious Disease are covered by a third-party payer, Carolina Infectious Disease may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third-party payer determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.
6. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS:** I authorize and release Carolina Infectious Disease and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Carolina Infectious Disease may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

1774 Metromedical Drive, Fayetteville, NC 28304-3861 Phone: (910) 568-3903 Fax: (910) 568-3908

7. **NO GUARANTEE OF RESULTS:** Carolina Infectious Disease physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Carolina Infectious Disease, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Carolina Infectious Disease or its employees.

I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

By signing, I also certify that I have received a copy of the Notice of Privacy Practices.

____

Printed Name

____

Patient/Guardian Signature

____

Date Signed