Clear Lake Specialties, PA

Patient Registration Form

PATIENT INFORMATION

Today's Date____ **DOB**_________________________________

Patient's Name_______________________________, ___________________________________, _________________
(Last) (First) (Middle Initial)

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security _______-_______-_______ **Gender:** ☐Female ☐Male ☐Transgender

Race ☐ American Indian/ Alaskan ☐ Asian ☐Native Hawaiian/ Pacific Islander ☐ White ☐ Hispanic ☐Black/African American ☐Other

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/ Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Hindu/Urdu ☐ Arabic ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ Other

Email Address ____

Phone Numbers: Home _______________________ Cell_________________________ Work_____________________

Address____
Street Name City, State Zip Code

PCP____ **Referring Provider**___________________________________
(Primary Care Physician)

Phone Number ___________________________________ **Phone Number** ___________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact: Name_____________________________________ Number________________________________

Relationship to Patient____

PHARMACY INFORMATION

Pharmacy Name____ Number________________________________

AUTHORIZATION TO RELEASE INFORMATION

Name_______________________________________ Relationship to Patient _________________________________

Name_______________________________________ Relationship to Patient _________________________________

Name_______________________________________ Relationship to Patient _________________________________

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____________________________________ Date _______________________

Clear Lake Specialties, PA

Patient Name: ______________________________________ DOB: ________________________

Please initial and sign the following statements.

INSURANCE COVERAGE WAIVER:

I wish to receive medical services from Clear Lake Specialties, PA. If my insurance does not cover all or part of the charges, I will be financially responsible for the remainder of the charges.

Initial: _______________________

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim.

Initial: _______________________

MEDICAL RECORDS RELEASE:

I hereby authorize the release of all hospital records, clinic records, and laboratory and radiology reports to Clear Lake Specialties, PA as necessary for medical care.

Initial: _______________________

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of Clear Lake Specialties, PA, notice of privacy practices.

Initial: ______________________

NO SHOWS AND CANCELLATION POLICY:

You are required to call at least 48 hours in advance to cancel your appointment. There will be a $25 fee for no shows and cancellations that occur less than 48 hours before your scheduled appointment.

Initial: ________________________

Signature: ____ Date: _____________________________

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance or government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services provided at this encounter.

I understand that if **Clear Lake Specialties, PA** or *any of its subsidiaries* is not paid in full by proceeds from any insurance policies then I may be responsible for all or part of the remaining balance due. I can request a complete copy of this Assignment of Benefits by asking the clinic staff or viewing online at:

https://www.clearlake-specialties.com/insurance-billing-assignment-of-benefits/

This Assignment shall be valid for one year unless revoked sooner.

____

Print Name of Patient

____ ________________________________

Patient Signature Date

Clear Lake Specialties, PA

Advance Beneficiary Notice (ABN) Form

Commercial/Medicaid

Patient Name: ____ DOB: ___________________________

Insurance: ____

You are receiving this notice because your insurance may not pay for all of the services that you receive during your office visit.

Please read this notice, so you can make an informed decision about your care.

______ Yes: I want to receive these services. If my insurance carrier denies payment, I am completely responsible for payment in full.

______ No: I have decided not to receive these services.

______OTHER: Should I decide to request these services in the future I understand I will be charged and am responsible for payment in full.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services performed if your insurance company denies coverage for the listed items.

Signature: _________________________________ Date: ________________________________

Clear Lake Specialties, PA

Advance Beneficiary Notice (ABN) Form

Medicare

Patient Name: ____ DOB: __________________________

You are receiving this notice because Medicare may not pay for all of the services that you received during your office visit.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) – Medicare

Note: If Medicare does not pay for the services provided you may be asked to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. If Medicare does not pay for the services, you may receive a bill for any unpaid services in which we have provided.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have but Medicare cannot require us to do this.

OPTIONS: Please check only one box. We cannot choose a box for you.

_______ **Option 1**. I understand I may be asked to pay now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay. I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, I may request a refund on payments I made to you, less con-ins or deductibles.

_______ **Option 2**. Do not bill Medicare. I understand I may be asked to pay now as I am responsible for payment I cannot appeal if Medicare is not billed.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)

Signing below means that I have received and understand this notice. I understand that I may request a copy.

Signature: ________________________________ Date: ________________________________

Clear Lake Specialties, PA

New Patient Information

Today's Date: ______________________________ Doctor's Name: ______________________________

Patient's Name: ______________________________ Date of Birth: ______________________________

Patient History

Reason for today's visit: ____

____

____

Medications

Please list the name, dosage, and how often you take the medication.

Please include IV antibiotics, nebulizer medications, vitamins, over the counter and prescription meds.

1)____

2)____

3)____

4)____

5)____

6)____

7)____

8)____

9)____

10)____

11)____

12)____

13)____

14)____

15)____

16)____

17)____

18)____

19)____

20)____

Allergies

1) Medications: ____

____

2) Food: ____

____

3) Other: ____

____

Clear Lake Specialties, PA

New Patient Information

Please let us know if you have been diagnosed with any of the following:

- ☐ Anemia
- ☐ Angina Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain/injury
- ☐ Bleeding Disorders
- ☐ Blood clots in the legs or lungs
- ☐ Bronchitis
- ☐ Cancer; where? ______________________________
- ☐ Cirrhosis of the liver
- ☐ Compression fracture
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombus
- ☐ Depression/Nervous disorder
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Eye Problems
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter/thyroid disorder
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Problems, Other
- ☐ Hepatitis
- ☐ Hernias, Hiatal or Other
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Kidney/Bladder infection
- ☐ Migraine headaches
- ☐ Osteoporosis (thinning of bones)
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Prostate enlargement
- ☐ Prostate infection
- ☐ Psychiatric Illness
- ☐ Pulmonary Embolus
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TB Tuberculosis
- ☐ Lung Problems, Other
- ☐ Ulcers
- ☐ Urinary Problems

Women Only

- ☐ Currently on birth control pills
- ☐ Recurrent Vaginitis
- ☐ Endometriosis
- ☐ Ovarian cysts or tumors
- ☐ Pelvic Infection
- ☐ Menstrual Disorders
- ☐ Recent Miscarriages

OTHER: If there are other illnesses not listed here, please write them in the space below:

____

____

____

____

____

Clear Lake Specialties, PA

New Patient Information

Surgeries

Please tell us if you have had any of the following surgeries and list the date of each one.

- ☐ Lungs/ Chest: What kind? ______________________ Date: ______________
- ☐ Heart: What kind? ______________________ Date: ______________
- ☐ Abdominal: What kind? ______________________ Date: ______________
- ☐ Gallbladder: ______________________ Date: ______________
- ☐ Appendix: ______________________ Date: ______________
- ☐ Hernia: ______________________ Date: ______________
- ☐ Eyes: ______________________ Date: ______________
- ☐ Prostate: ______________________ Date: ______________
- ☐ Hysterectomy: ______________________ Date: ______________
- ☐ Mastectomy: ______________________ Date: ______________
- ☐ C-Sections: ______________________ Date: ______________
- ☐ Others: ______________________ Date: ______________

____

Hospitalizations

Have you ever been hospitalized for any reason? Please explain and list the dates

Date:______________________ Reason: ______________________

Date:______________________ Reason:______________________

Date: ______________________ Reason: ______________________

Date:______________________ Reason: ______________________

Immunizations/ Vaccines

When was the last time you had the following vaccines:

Pneumonia: ______________________ Flu Shot: ______________________

Hep A:______________________ Tdap: ______________________

Hep B: ______________________ Other: ______________________

Clear Lake Specialties, PA

New Patient Information

Family History

Did any blood relatives (parents, grandparents, children, brothers, or sisters) have any of the following

If yes, please list who had the illness.

☐ Asthma ____

☐ Tuberculosis ____

☐ Heart Disease ____

☐ Diabetes ____

☐ Hypertension ____

☐ Lung Disease ____

☐ Cancer ____

☐ Stroke ____

☐ Excessive Bleeding ____

☐ Thyroid ____

☐ Arthritis ____

☐ Glaucoma ____

☐ Others ____

Social History

Did you ever smoke cigarettes, cigars, or pipes?

How many packs per day __________ How many years? _________ Age quit?___________

Did you ever drink alcohol? If so, what type?

How many drinks per week__________ How many years? ________ Age quit?__________

Who do you live with? ____

Do you have any pets? What kind? ____

What jobs/occupations have you had during your lifetime? ______________________________

____

Were you ever exposed to excessive dust, asbestos, sand etc.? ___________________________

____

Have you travelled outside the US? If so, when? ______________________________________