Sacred Circle HEALTHCARE | A CTGR Entity

660 South 200 East Ste. 250 Salt Lake City, UT 84111
Phone: 801-359-2256 Fax: 801-364-4392

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX YOU IDENTIFY AS: ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____

Email:	Ethnicity:	Language:	Race:
	❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report	❑ English ❑ Spanish ❑ Other, please list below	❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Pacific Islander ❑ Other Race ❑ Unreported/Refused to Report

CTGR Member: ❑ Yes ❑ No Non CTGR Tribal Affiliation: Enrollment ID:	Refugee: ❑ Yes ❑ No

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE

Is the patient a minor child and do you authorize a different adult (non-parent or Guardian at least 18 years old) to consent to care in your absence? ❑ Yes ❑ No Authorized Adult:	Does this consent include procedures, immunizations, and prescribing medications? ❑ Yes ❑ No

INSURED/RESPONSIBLE PARTY INFORMATION Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self

Relation to Insured ❑ Parent ❑ Guardian ❑ Other: Please specify

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	SUBSCRIBER/ID NUMBER	EMPLOYER	EMPLOYER PHONE

SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	SUBSCRIBER/ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFERRING DOCTOR	
IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP	PHONE NUMBER
Does the above mentioned emergency contact have permission to discuss your protected health information: Yes_____ No _____	Preferred Pharmacy/Location:	

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES

_____ **(Patient Initials)** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

RELEASE OF INFORMATION

_____ **(Patient Initials)** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other Sacred Circle affiliated facilities may be made available to subsequent Sacred Circle affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s)	**Relationship:**	**Contact Number:**
Name(s)	**Relationship:**	**Contact Number:**

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

I wish to designate individual(s) to pick up a prescription order on my behalf: ❑ **Yes** ❑ **No**

Name(s)	Name(s)

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PATIENT FINANCIAL POLICY

_____ **(Patient Initials)** I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Sacred Circle Health Care Financial Policy Form. There is a detailed form available upon request.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

_____ **(Patient Initials)** I consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recording will be securely stored and protected. Images and/or recordings in which I am identified will not be released and or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted by law.

CONSENT TO EMAIL OR TEXT MESSAGE USAGE FOR APPOINMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

We want to stay connected with our patients.
Patients in our practice may be contacted vial email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your wireless carrier for pricing plans and details).

CELL PHONE AUTHORIZED:	**EMAIL AUTHORIZED:**

Opt Out of text and email alerts ❑ **Yes** ❑ **No**

PATIENT ATTESTATION:

I attest that all of the information providers is correct and true to the best of my knowledge.

Patient/Parent/Guardian/Patient Representative Signature:	**Date:**
Patient/Parent/Guardian/Patient Representative Name (Printed):	**Date:**
Witness Signature	**Date:**

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PATIENT CONSENT FORM

CONSENT TO MEDICAL SERVICES

_____ **(Patient Initials)** I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency) if a physician orders such tests for diagnostic purposes.

ASSIGNMENT OF BENEFITS

_____ **(Patient Initials)** This assignment of benefits allows the health care facility and/or facility-based physicians to be paid directly by my health insurance carrier or other health benefit plan for the laboratory services, the pharmacy services, the healthcare facility and/or facility-based physicians provide to me. In return for the services rendered and to be rendered by the facility and/or facility-based physicians all right, title, and interest in all benefits payable for the laboratory services rendered, which provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the health care facility and/or facility-based physicians an independent right of recovery against my insurer or physicians to pursue any such right of recovery. In no event will the healthcare facility and/or facility-based physicians retain benefits in excess of the amount owed to the healthcare facility and/or facility-based physicians for the care and treatment rendered during my visits.

PAYMENT AGREEMENT

_____ **(Patient Initials)** The patient/responsible party or legal guardian obligates him or herself to the payment of practices account incurred in accordance with the regular rates and terms of the practice at the time of discharge. If the patient/responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

MEDICARE PATIENT CERTIFICATION

_____ **(Patient Initials)** I certify that the information given by me in applying the payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

_____ **(Patient Initials)** I agree that, in order for Sacred Circle Healthcare, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Sacred Circle Healthcare or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation or wireless, I have provided or Sacred Circle Healthcare or EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

CERTIFICATION

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the healthcare facility and/or facility-based physicians.

Patient/Parent/Guardian/Patient Representative Signature:	**Date:**
Patient/Parent/Guardian/Patient Representative Name (Printed):	**Date:**
Witness Signature:	**Date:**

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CLINIC POLICIES AND GUIDELINES

PATIENT RESPONSIBILITY

- Please notify us with any changes of information, including but not limited to, address, phone numbers, email address, marital status, medical history, insurance coverage ***prior*** to seeing your provider.
- Please turn off any cell phone devices in our office. Cell phones may interfere with our high-tech equipment or disrupt other patients in our office.

APPOINTMENTS

- A ***24-hour notice*** is required to cancel an appointment. If we are given less than 24 business hour notice, it is considered a ***No-Show*** (broken appointment).
- After 2 broken appointments, ***we will not be able to schedule*** you another appointment. We value you as a patient and would still like to see you on a ***Walk-In*** basis.
- If you are placed on ***Walk-In Status*** you must call and see if there is room that day for you to come in and be seen. There may be a longer wait time as we will be working you into our schedule.
- ***Please make every effort to keep your scheduled appointments. Missed appointments may generate a $25 fee.***
- To prevent inconvenience and to respect our patients time, ***"Late Patients"*** (5 minutes past appointment time), may need to be rescheduled.

FINANCIAL GUIDELINES

- A parent or guardian must sign for children under the age of 18 years old. The parent or guardian that signs the patient in is responsible for the patient's account.
- ***We do not bill for services.*** We ask that all payments be received ***at the time services are rendered***. Those who have insurance are responsible for the ***deductible*** and/or ***co-pay*** at the time of service. We will make our best estimate of your insurance coverage; however, you are responsible for knowing the level and extent of your insurance benefits.
- Your insurance policy is a contractual agreement between you and your insurance company. If your insurance company has not paid your claim in a timely manner (45 days), it will be necessary to change the account balance to patient responsibility.
- You are financially responsible to Sacred Circle Health Care for your account. If your account becomes overdue and/or delinquent, you will need to pay any fees associated with getting your account paid in full.

PRESCRIPTIONS

- The patient will take medication only as prescribed. Patients who take more than the prescription indicated will not be prescribed additional medication.
- Only patients for whom the prescription is written are allowed to use the medications. There will be ***no refills*** for lost, stolen or misplaced narcotic prescriptions.
- Any attempt to obtain additional medications from another physician may be considered attempting to abuse narcotic prescriptions and may be referred to legal authorities for appropriate and/or dismissal from the practice.
- Please call ***at least 72 hours*** in advance for all medication refill requests.

OUR COMMITMENT

Our goal at Sacred Circle Health Care is to treat you the way you want to be treated. We value our relationship with you, and we will provide you with the most modern, high tech and comfortable healthcare available. Please let us know ***what matters most to you***, so we can give you the type of treatment and care that you deserve.

CERTIFICATION

I acknowledge that I have read and understand the above policies and guidelines. I also understand that if I have questions or concerns, I may request to speak with a member of the management team.

Patient/Parent/Guardian/Patient Representative Signature:	**Date:**
Patient/Parent/Guardian/Patient Representative Name (Printed):	**Date:**