Brandywine Family Medicine
Valerie Elener MD
2500 Grubb Road Suite 212
Wilmington, DE 19810

New Patient Registration Form.   Patient Information

Last name ____

First name ____ Middle initial ________

What do you want us to call you ______________________________________

Sex you identify with now ___ male ___ female ___   ___________________________

Social security number ____

Are you ___ single ___ married / partner ___ divorced ___ widowed

Are you ___ working ___ retired ___ disabled ___ visually impaired ___ hearing impaired

Occupation ____

Primary language ___ English or ____________________________________

Can you read your language to use google translate ______________________________

Address ____

City, State, Zip ____

Home phone number ______________________________________

Cell phone number ____

Preferred method of contact _____________________________

Email (for patient portal account) ____

Emergency Contact Information

Name ____

Relationship to you _______________________________________

Phone number ____

Preferred local pharmacy and location ____

Mail order pharmacy ____

Primary insurance information

Company ____

ID number ____

Group ID number ____

Effective Date of Insurance ____]

Is the patient the owner of the policy ___ yes ___ no

IF no Last name of policy owner __________________________ first name ______________

Date of birth of policy owner ____

Social Security number of policy holder ____

Secondary insurance information

Company ____

ID number ____

Group ID number ____

Effective Date of Insurance ____

Is the patient the owner of the policy ___ yes ___ no

If no Last name of policy owner ______________________________ first name __________________

Social security number of policy holder ____

Commercial or Medicaid Authorization
I authorize the release of medical information necessary to process claim forms and the payment of medical benefits to Dr.. Elener for medical services rendered. A copy of this authorization shall be as valid as the original.

Full Name ______________________________________ Date _______________________________

Signature ____

Medicare lifetime signature on file
I authorize any holder of my medical or other information to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or any other related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Dr. Elener who accepts assignment of Medicare. Regulations pertaining to Medicare assignment of benefits apply.

Full Name _______________________________________ Date ______________________________

Signature ____

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Patient privacy consent form   HIPAA authorization
This authorization is effective indefinitely unless revoked or terminated by patient

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Brandywine Family Medicine of its Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices, from time to time, and that I may contact this office at any time to obtain a current copy of the Notice of privacy practices..

I understand that I may request in writing that the office restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke or terminate this consent in writing at any time, except to the extent that you have taken action relying on this consent.

This authorization is effective indefinitely unless revoked by myself or personal representative.

Patient name ____

Signature ____

Date ____

Relationship to patient if other than patient ____

If you would like to give permission to Dr. Elener and staff to discuss your medical condition and health with a family member please provide their name and relationship to you. This would include any questions for the office regarding my health, appointments, prescription refill requests and concerns about my health my friends or family may have.

Name ____ Relationship _____________________

Name ____ Relationship _____________________

Name ____ Relationship _____________________

Name ____ Relationship _____________________

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Financial Policy

* I understand that it is my responsibility to provide your office with current, accurate billing information at the time of check in and to notify you of any changes in this information.

* I understand that it is my responsibility to understand my health insurance policy prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that your office also has a contractual agreement with my health plan to collect co-pays at the time of service, and you are required to report to the carrier any enrollees failings to pay their co-pay.

* I understand that if I present an insufficient funds check (NSF) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check or credit card.

* I understand that there is a $25 fee to complete disability paperwork associated with my care and a $25 fee to complete FMLA paperwork. All paperwork fees must be paid prior to completion.

* I understand that I will be billed for any amounts due by me (copayments/coinsurance amounts / deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the third statement will be marked as Final Notice and will be sent to an outside collection service. (Transworld Systems, Inc.) if I do not fulfill my financial obligations. I understand that if my account is turned over to a collection agency a service charge will be added to the balance.

* I understand that if I have an unpaid balance more than 90 days old that non urgent medical care may be withheld until such balances are paid.

* I understand that Dr. Elener reserves the right to charge a cancellation fee for no show, missed or cancelled office visits without 24 hours advance notice of $30 and the right to charge a cancellation fee for missed or cancelled procedure, wellness or pre op visits without 24 hour notice of $50.

My signature below confirms that I have read the above policies and understand. My obligations as a patient..

Patient Name ____

Date of birth ____

Signature ____

Date ____