PATIENT REGISTRATION

SSN:	Last Name:	First Name:	Middle Initial:
Address:	City:	State:	Zip:
Date of Birth:	Sex:	Marital Status:	Email Address:
Home Phone:	Work Phone:	Cell Phone:	Employer Name:
Emergency Contact:	Relationship:	Phone:	
If minor, Responsible Party's Name:	Relationship:	Phone:	
Primary Insurance:	Policy Holder:	Relationship:	Date of Birth:
Secondary Insurance:	Policy Holder:	Relationship:	Date of Birth:

CONSENT & CONDITIONS FOR TREATMENT

1. Consent for Treatment
   a) I, or ______________________as my authorized representative acting on my behalf, present myself for treatment at ECLECTIC FAMILY CARE, LLC. In so doing, I hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical and surgical procedures, by authorized members of the ECLECTIC FAMILY CARE, LLC staff or their designees, as may in their professional judgment be deemed necessary or beneficial
   b) I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the results of any examination or treatment
   c) I further understand that I have the right, in collaboration with my physician(s), to make decisions involving my health care and to accept care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
2. Financial responsibility / Assignment of Insurance Benefits
   a) I agree to pay ECLECTIC FAMILY CARE, LLC for any and all charges billed services rendered. I understand that such accounts are due at the time of service, but that ECLECTIC FAMILY CARE, LLC, may accept assignment of insurance benefits in lieu of such payments. I understand that if I have insurance, that any co-payment or non-insured service amounts are payable at the time of service.
   b) I acknowledge that ECLECTIC FAMIY CARE, LLC will make reasonable efforts to collect my assigned insurance benefits. Should said benefits remain unpaid sixty (60) days after my discharge, payment of the full amount shall be my responsibility. I further understand that is my account remains unpaid for a period of ninety (90) days, that \it may be turned over to a collection agency to expedite collections, in which case I will be liable for all collection costs including a reasonable attorney's fee.
   c) I hereby assign any third-party payments due me or that may become due to me under all policies of insurance held by me or for my benefit for services rendered on this date; or any relate treatment, to ECLECTIC FAMILY CARE, LLC. Should the payment(s) received exceed the current billed charges, then I authorize the application of any excess amount to any other ECLECTIC FAMILY CARE LLC bill owed by me or any member of my family for whose bill I would be otherwise responsible for. A copy of this assignment shall be as valid as the original.
3. Medicare Assignment
   a) I hereby certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries of carries any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I hereby assign benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment on my behalf.
4. Release of Patient / Medical Information
   a) I consent to the release of personal and medical information to any third-party payor, governmental agency providing benefits or other person(s) / entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate my use of community resource and / or for transfer to another health care facility.

I have had an opportunity to read this form and any questions answered to my satisfaction, and I am satisfied that I understand its content and significance.

_________________________ _________________________

Insured's Signature & Date Patient/Legal Guardian Signature & Date

Eclectic Family Care, LLC
575 Claud Road
Eclectic, AL 36024
334-541-3020

Patient Consent to the Use and Disclosure of Medical Records for Treatment, Payment, or Healthcare Operations

I, ______________________________, understand that as a part of my healthcare, Eclectic Family Care, LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future health care treatment. I understand that this information serves as:
A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing this consent.
The right to reject the use of my health information for directory purposes,
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

In addition to myself, I consent to the following adult individuals to have access to my medical records. (Please give full name and address)

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I understand that Eclectic Family Care, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Eclectic Family Care, LLC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

____ ______________________

Patient's Signature Date

FOR OFFICE USE ONLY
( ) Consent received by ______________________________ on ____________________
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical records on ______________________________

ECLECTIC FAMILY CARE, L.L.C.
Gary L. McCulloch, MD
Christopher Pritchett, CRNP
Laura H. Smith, CRNP
P.O. Box 241120 Eclectic, AL 36024
Phone (334) 541-3020 Fax (334) 541-3109

PATIENT PORTAL

Patient Name ____

Date of Birth ____

We offer the patient portal and patients have the ability to perform the following functions via the portal. When signing up an email will be sent with your personal credentials for logging into the portal to the email address you provide.

Request a Medication Refill
View Allergies & Medication
View Lab Results
View/Download Clinical Summary
Download Patient Education Documents

____ I am interested in signing up for the patient portal. (please provide email address below)

____

_____I am not interested in signing up for the patient portal.

Patient Signature: ____

Date: ____________________________