Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient: _____
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( )_____- _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth: *//*	Phone:
Social Security No.:	Mobile Phone:( )_____- _____
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____**Date:**_____

General Consent for Care and Treatment

I, **{{PATIENTNAME}}**, voluntarily request the physicians and staff of Tryon Medical Partners, PLLC to perform reasonable and necessary medical examination, testing and treatment for the condition(s) which caused me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
You have the right to discuss the treatment plan with your physician about the purpose, potential risk and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

_____ **I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. (Initials)**

Assignment of Benefits and Billing Authorization Form

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to Tryon Medical Partners, PLLC, for the healthcare services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

_____ **I hereby authorize Tryon Medical Partners, PLLC, to release medical information to my insurance carrier to process claims and I assign my insurance benefits to be paid directly to Tryon Medical Partners, PLLC. (Initials)**

Acknowledgment of Receipt of the Notice of Privacy Practices

Tryon Medical Partners, PLLC, is required by law to maintain the privacy of your patient information. We are required to provide you with our Notice of Privacy Practices that describes our legal duties and privacy practices with respect to your protected health information. If you object to the Notice, you may speak to the Privacy Official whose name and contact information is in the Notice of Privacy Practices. If you would like a copy of our Notice, please ask.

_____ **I acknowledge that I have had an opportunity to receive and review a copy of the Notice of Privacy Practices. (Initials)**

Patient No-Show Policy

All patients are expected to arrive at least 15 minutes prior to their scheduled appointment time. Patients who cancel after 5pm the preceding business day before their scheduled appointment, or do not present to the clinic for their appointment, are considered a 'NO SHOW' and are subject to a no-show fee. All no-show patients are subject to a $50 fee, payable only by the patient (not insurance). Any patient with more than three (3) no-shows in a 36-month period will be subject to dismissal from Tryon.

_____ **I acknowledge that I have read and understood the Tryon Patient No-Show Policy. (Initials)**

Patient Name	Signature	Date

Guardian/Beneficiary (printed name)	Signature	Date