KAPLAN CENTER FOR INTEGRATIVE MEDICINE / KAPLAN CLINIC
Patient Registration Form

PLEASE PRINT

Patient Name: _____ Name you prefer to be called: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____ Email Address: _____

SS#: _____ **Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Committed Relationship

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Whom should we thank for referring you? ☐ Friend/ Family ☐ Physician: _____

☐ Media: _____ ☐ Internet: _____

☐ Other, please specify: _____

Financially Responsible Person: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Relationship): _____

Name: _____ Phone: ☐ Home ☐ Work ☐ Cell _____

Address: _____ **Responsible Party's Signature**: _____

Responsible Party's Employment Status: ☐ Employed ☐ Retired ☐ Student Employer: _____

Emergency Contact: ☐ Same as Financially Responsible Person **Relationship**: _____

Name: _____ Phone: ☐ Home ☐ Work ☐ Cell _____

Address: _____

Please initial: I certify that I DO NOT have Medicare: _____ Medicaid: _____ Tricare/Champus: _____ Insurance Coverage.
Initial: I certify that if I have Medicare, I only have original Medicare: _____ an advantage plan: _____ Part A *only*: _____ Part B: _____

I certify that I AM NOT seeking treatment for a work-related accident of occupational disease that might be covered under a worker's compensation plan provided by my employer. Please initial: _____

I**nsurance Information:**

Primary Medical Insurance Company: _____

Address: _____ Phone: _____

Insured / Card Holders Name: _____ Relationship: _____ Insured's Date of Birth: _____

Policy #: _____ Group #: _____ Group Name: _____

Secondary Medical Insurance Company: _____

Address: _____ Phone: _____

Insured / Card Holders Name: _____ Relationship: _____ Insured's Date of Birth: _____

Policy #: _____ Group #: _____ Group Name: _____

I voluntarily present myself for treatment at the Kaplan Clinic, and I herby authorize my physicians and such associates, assistants and designees as they may select and the staff, agents and employees to perform, and I herby consent to, such medical care, including diagnostic procedures, medical treatments and examinations, as may be necessary in the opinion of my physicians.

I hereby authorize Kaplan Clinic to apply for benefits on my behalf for services rendered. I request payment be made directly to Kaplan Clinic, PC. I certify that the information I have provided is true and accurate. I further authorize the release of any medical information or other information for this or any related claim to any insurance company.

I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if my balance remains unpaid for 45 days or more, it will be subject to an 18% annual interest rate, and if it becomes necessary to refer my account to a collection agency, I agree to pay the collection costs.

Patient Signature: _____ Date: _____

Signature of Parent or Legal Guardian (if applicable): _____

KAPLAN CENTER FOR INTEGRATIVE MEDICINE
CONFIDENTIAL COMMUNICATION REQUEST FORM

You have a right under the HIPAA guidelines to request the type of confidential communications you would like to have with the Kaplan Center. To help us get your healthcare information to you in an efficient manner, please complete this form identifying your wishes. We will accommodate reasonable requests. As always, the Kaplan Center is dedicated to maintaining the privacy of your healthcare information.

Phone communication:

Do you authorize the Kaplan Center to leave a message on your answering machine containing the caller's name, the Kaplan Medical Center office phone number, and a brief description of why we are calling (which may include the name of your physician or healthcare provider)?

I authorize the Kaplan Center to leave this type of message:

At my home number: **Initial**:_____ On my cell phone number: **Initial**:_____
At my work number: **Initial:**_____ Do not leave a message: **Initial:** _____

In the event that the Kaplan Center would need to leave a more involved message including detailed Protected Health Information (**PHI**), do you authorize leaving a message with PHI on your answering machine? For example: "Your throat culture was positive, please continue your antibiotics." or "We received your x-ray results and your chest x-ray is normal."

I authorize the Kaplan Center to leave this type of message:

At my home number: **Initial**:_____ On my cell phone number: **Initial**:_____
At my work number: **Initial:**_____ Do not leave a message: **Initial:** _____

Paper Communication:

In the course of meeting my healthcare needs:

I authorize the Kaplan Center to send PHI via regular mail. **Initial:** _____
I understand that if I do not initial the above box I will be charged for certified, return-receipt-requested postage when PHI is mailed to me. **Initial:**_____

At your request, the Kaplan Center may fax your PHI to your **personal** fax.
Upon my verbal request, I hereby authorize the Kaplan Center to fax my PHI to the following:

Fax number:_____ **Initial**:_____

Pharmacy Communication:

The Kaplan Center communicates with pharmacies electronically, via phone, and via fax. By initialing below, you authorize the Kaplan Medical Center to communicate your pharmacy.

I authorize the Kaplan Center to communicate with my pharmacy:

Via phone: **Initial:**_____ Via fax: **Initial:**_____ Electronically: **Initial:**_____

Electronic Communication:

Do you authorize the Kaplan Center to send you non-protected information via e-mail, including the Kaplan newsletter, and other general notices such as the availability of flu shots?

I authorize the Kaplan Center to send information to my e-mail address below:
_____ **Initial**: _____

Appointment Reminders:

The Kaplan Center offers patients multiple types of automated appointment reminders. Patients are automatically enrolled in automated telephone calls and emails, and may enroll in text messaging as well.

Via phone: **Initial:**_____ Via text: **Initial:**_____ Via email: **Initial:**_____

Print Patient Legal Name:_____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
Patient/ Legal Guardian **Signature:** _____ Date:_____