The McGregor Clinic, Inc.

Patient Registration

Last Name_____ First Name_____ Middle Initial_____

Patient DOB: _____ Social Security Number_____ Sex: M or F

Physical Address_____City_____ State____ Zip_____

Mailing Address _____City_____State ____Zip_____

Home Phone Number_____ Work_____ Cell_____

Okay to leave a voicemail? Y or N preferred phone number _____

Employer_____ E-Mail Address _____

Who Should We Thank For Referring You_____

Primary Care Physician_____

Marital Status: Single, Married, Divorced, Widowed, or Separated

Employment: Full Time, Part Time, Not Employed, Self Employed, Retired, or Military Duty

Insurance Information

Name of Insurance(s) _____ Effective Date_____

ID# _____

Subscriber Information

Name of Policy Holder_____

Relationship to the patient: Self, Spouse, Child, Other _____

Date of Birth_____ Social Security Number_____ Employer_____

Address (if different than patient's) _____

Home Number_____ Work/Cell Number_____

Secondary Insurance Information (If Applicable)

Name of Insurance(s) _____ Effective Date_____

ID#_____

Emergency Contact Information

Name_____ Phone Number_____

Relationship_____

The Emergency Contact information will only be used in the event that a release cannot be signed due to a medical emergency. A consent to share information must be signed and on file for any other correspondence with the person listed above.

Current Pharmacy

Pharmacy Name _____ Location _____

Due to new Healthcare Reporting guidelines, The McGregor Clinic, Inc. is requesting the following information to get a better sense of the overall diversity of our patient population and have a better understanding of our practice and patient needs. This confidential information will assist us in improving the quality of care you receive in our office.

Please place a check mark to the left of whichever option applies:

1) Primary Language: ____English ____Spanish____ Haitian Creole ____Portuguese ____French

____Other _____

2) Race: Choose all that apply:

_____Asian
- _____Asian Indian
- _____Chinese
- _____Japanese
- _____Korean
- _____Vietnamese
- _____Other Asian

____Native Hawaiian or Other Pacific Islander
- ____ Native Hawaiian
- ____ Guamanian or Chamorro
- ____ Samoan
- ____ Other Pacific Islander

____American Indian or Alaska Native

____Black or African American

____White

____Unreported/Refuse to Report

3) Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Unreported/Refuse to Report
- ____ Mexican, Mexican American, Chicano/a
- ____ Puerto Rican
- ____ Cuban
- ____ Another Hispanic, Latino/a or Spanish origin

4) Agricultural Status: _____ Migrant Worker _____Seasonal Worker _____ N/A

5) Annual Household Income $_____ # of Family Members in household _____

(Please note that if payment assistance is requested verification of income will be required)

6) I acknowledge that the information provided is accurate and true to the best of my knowledge.

_____
Print Name

_____ _____
Signature of Patient or Representative **Date**

INITIATION OF SERVICES

PART I CLIENT – PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: **McGregor Clinic, Inc.**
Agency Address: **3487 Broadway Avenue**
Fort Myers, FL 33901

I consent to entering into a client-provider relationship. I authorize The McGregor Clinic, Inc. and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examinations, administration of medications, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its internediaries / carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client/Representative signed below, I, assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____
Client/Representative Signature | Self or Representative's Relationship to Client | Date

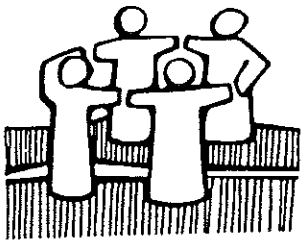
_____ _____
Witness (Optional) | Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____(Date).
Client/Representative Signature

_____ _____
Witness (Optional) | Date

Client Name: _____
ID#: _____
DOB: _____



THE McGREGOR CLINIC

". . . giving voice to patient choice."

PATIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURE

RIGHTS

- You have the right to receive timely, respectful, high quality services without regard to age, ethnicity, gender, disability, religion, sexual orientation, values and beliefs, and marital status.
- You have the right to request copies of all signed documents and have access to your medical records.
- You have the right to participate in the development of your plan of care.
- You have the right to choose the provider and the type of services and care required within the scope of clinical responsibility.
- You have the right to receive current information and education about the disease, the medicines and treatment.
- You have the right to appeal decisions with which you do not agree and to file a patient grievance.
- You have the right to request an interpreter to enhance communication. We suggest the arrangements be made well enough in advance.
- You have the right to refuse recommended treatment plans as allowed by law based upon the patient's judgment of risks and benefits and without pressure or unwanted influence from your health care provider.

RESPONSIBILITES

- You are responsible to conduct yourself in a courteous and respectful manner and also to respond in a timely manner to all your appointments.
- You are responsible for keeping all appointments.
- You are responsible for notifying your provider if any illness interferes with scheduled appointments.
- You are responsible for working with your health care provider to develop a plan of care.
- You are responsible for providing any and all necessary documentation needed to assist in enrolling you in any eligible programs or services.
- You are responsible for following the instructions of your health care provider to the best of your ability.
- You may be responsible for a portion of the costs of your health care services.
- You are responsible for notifying your health care provider of any changes such as address and financial eligibility.

GREIVANCE PROCEDURE

- If you are dissatisfied with the services you are receiving, you may voice a complaint or grievance to your health care provider.
- If you are not satisfied with the results, you may, within 30 days, submit your concerns in writing to the McGregor Clinic, Inc. Board of Directors. The Board of Directors is responsible in resolving issues in any manner they see fit with the solution being presented to the patient in writing. You have 10 days to appeal the Board's decision.

I have had the opportunity to discuss and I am fully aware of the Rights, Responsibilities and Grievance Procedures outlined above.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

3487 Broadway • Fort Myers, FL 33901

Phone: (239) 334-9555 • Fax: (239) 334-2832 • E-mail: McGregorClinic@aol.com

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Client Name _____ DOB _____ SSN _____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. The authorizations designated on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of all parts of this authorization upon your request.

Section 1 – Authorization for Release of Medical Information
I, _____, do hereby authorize _____ to release to _____ the following for the purpose of disease management and continuing care, or for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Information to be disclosed (Initial Sections):
_____ General medical records created at _____
_____ The following information from the medical record _____
_____ Records obtained from the following providers _____
_____ STD Records
_____ Psychiatric/psychological information/records
_____ TB Records
_____ HIV/AIDS records
_____ Drug/alcohol treatment records
_____ Consent to fax/mail

Section 2 - Medicare Patient Certification, Authorization to Release and Payment Request (only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries / carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above agency and authorize it to submit a claim to Medicare for payment.

Section 3 – Consent to Share Information
As Client/Representative signed below, I hereby authorize the McGregor Clinic, Inc., and any practitioner examining or treating me to share information with _____, in order to maintain continuity of care. Information may include psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, adult or child abuse information including any information received from other healthcare providers concerning diagnosis and treatment.

Section 4 – Assignment of Benefits (only applies to Third Party Payers)
As Client/Representative signed below, I, assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

Redisclosure: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Revocation: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Client/Representative Signature **Date**

_____ _____
Representative's Relationship to Client **Witness (Optional)**

3487 Broadway Avenue • Fort Myers, FL 33901
Phone: (239) 334-9555 • Secure Fax(es): Medical (239) 334-2832 / Case Mgt (239) 334-2439