COASTAL MEDICAL CENTERS
Coastal Primary Care
16479 South Dupont Highway, Harrington, DE 19952

****Please call your insurance and list our office as your new Primary Care Provider prior to 1st appointment****

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____

Middle Name: _____

Social Security Number: _____ DOB: _____

E-Mail: _____

Sex: Gender: _____ Marital Status: _____

Employer: _____ Occupation: _____

Home Phone: _____ Cell: _____

Home (Billing) Address: _____

City: _____ State: _____ Zip: _____

Parent / Guardian Name: _____

Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____

Preferred language: _____ Race: _____

Insurance Information

Primary Insurance Company: _____Co-Pay Amount: _____

Insurance ID: _____ Group Number: _____

Insurance Holder's Name & Date of Birth: _____

Insurance Holder's Social Security Number: _____

Secondary insurance Company: _____

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MEDICATIONS

Allergies to Medications: _____

Allergies to Foods: _____

Pharmacy: _____ City / Town: _____

NAME	STRENGTH	TIMES PER DAY

PLEASE LIST ALL DOCTORS / SPECIALIST YOU SEE

Physicians Name	Specialty

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DO YOU HAVE OR HAVE YOU HAD ANY CURRENT MEDICAL CONCERNS WITH THE FOLLOWING?

CONDITION	YES	NO	EXPLANATION
EYES			
EARS			
HEADACHE			
NOSE			
THROAT			
LUNGS			
HEART			
STOMACH			
FOOD DIGESTION			
INTESTINES			
RECTUM			
CONSTIPATION			
DIARRHEA			
BLADDER			
KIDNEYS			
URINATION			
OVARIES/UTERUS/CERVIX			
BREAST			
THYROID			
MENSTRAUTION			
BLOOD DISORDER			
IMMUNE DEFICIENCY			
SEXUAL TRANSMITED INFECTION			
SKIN			
LEGS/ARMS/JOINTS			
DEPRESSION/ANXIETY			
MOOD CHANGES			
SLEEPING PROBLEMS			
PENIS/TESTICLES			

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19952

FAMILY MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

ILLNESS / CONDITION	YES / NO	FAMILY HISTORY	EXPLAIN
CANCER			
DIABETES			
HEART DISEASE			
PROSTATE			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
STROKE			
TUBERCULOSIS			
MIGRAINES			
BLOOD DISORDERS			
MENTAL ILLNESS			
THYROID DISEASE			
SEIZURES			
ASTHMA			
ARTHRITIS			
CHRONIC PAIN			
IRRITABLE BOWEL			

SOCIAL HISTORY

DO YOU OR HAVE YOU	YES / NO	HOW OFTEN	STILL DO
SMOKE CIGARETTES			
DRINK ALCOHOL			
RECREATIONAL DRUGS			

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COASTAL PRIMARY CARE RULES AND REGULATIONS

Please make sure the patient's insurance card and identification card are present during your appointment, along with any insurance co-pays.

Please notify the office immediately if your insurance changes and please bring us a copy of the new card for billing purposes.

We respectfully request a 24-hour advance notice if you need to reschedule or cancel your appointment. In the event that the appointment is not canceled (no-show), there will be a $25.00 charge.

Children under the age of 18 must be accompanied by a parent / guardian. If someone other than the parent or guardian is present with the child, then a note from the parent / guardian must be written and present with the patient at the time of the visit giving permission for treatment on that day.

Please allow 24 to 48 hours for all prescription refills to be completed by the office. Please be sure to call in your refill request to the office at least 3 days prior to your last dose, this will help to prevent from being out of medication(s). Make sure to call your pharmacy before picking up the medication to make sure the prescription is ready.

If you are referred to a specialist or require any type of diagnostic testing and your insurance requires a referral /authorization, please notify the nurse, and please allow 24 to 48 hours for the office to complete the referral / Authorization.

Health care providers reserve the right to discharge a patient from the practice for any reason they deem fit that includes but not limited to excessive cancellations or no-shows of scheduled visits, acting inappropriately in a healthcare setting, or being disrespectful to any of providers or staff members.

Please initial on the line below if you allow the office to leave a message on your voicemail regarding any appointment reminders (this includes but is not limited to specialists, medication refills, radiography studies, etc.

SIGNATURE: _____ **DATE:** _____

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PERMISSION TO TREAT

I hereby authorize Coastal Primary Care to evaluate and treat me for my presenting conditions. I Understand that the provider evaluating me may, in His / Her professional opinion, determine that I need to be transferred to a higher level of care such as the Emergency department. I agree to pay for all medical services rendered at Coastal Medical Center, Coastal Walk-In and or Coastal Primary Care

Name: _____

Signature: _____

Relationship if Guardian: _____

Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the below-named health care providers to release the information or records specified to in this request by mail, electronically, or in person to the address specified at the time of the request.

Previous provider name: _____

Phone Number: _____ Fax Number: _____

Please release information to:

Coastal Primary Care
16479 South Dupont Highway Harrington, DE 19952
(P) 302-587-5017(F) 855-592-2765

Patient Name:_____DOB:_____

All the records below are authorized to be released:

Office Notes, Discharge Summaries, Complete hospital chart, Admission history and physical, Outpatient records, Complaints or grievances filed, with responses or dispositions. Psychiatric and other mental health records, Records relating to drug or alcohol abuse.

(Must specify the extent or nature of the records to be released) _____

Medication logs, dietary logs, staff contact, service logs, and other records that may not be part of the individual medical record, but which contain information relating to me.
Other: _____

This information will be used for the purpose of the following as needed:

Investigating an allegation of abuse, other activities at the request of the individual Verifying my eligibility for services offered by

Legal Representation providing advocacy services.

This Authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

- **I understand that I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.**
- **Federal privacy regulations will no longer apply to the information disclosed and that Coastal Primary Care may re-disclose the information.**
- **I am entitled to receive a copy of this authorization.**
- **A copy of the authorization may be utilized with the same effectiveness as an original.**

Signature of patient or Representative: _____Date _____

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PATIENT / FAMILY FINANCIAL RESPONSIBILITY

I (We) jointly and severally, agree to pay all the charges for professional services rendered to the patient.

I (We) understand that these charges are in addition to charges by a hospital or other medical professional rendering services to the patient.

I (We) promise to pay the charges in full at the time a bill is presented unless other terms have been agreed to in writing. In the event prompt payment is not made, the undersigned understands that the account may be referred for collection. In such an event any unpaid balance shall accrue interest at the rate of 2% of the amount due. We also use Third Party vendors such as LabCorp, Quest, and Bay Health for labs and Imaging studies as well as Bregg for durable medical goods such as splints and crutches, etc. If you are self-pay and or your insurance does not cover these vendors, you may receive a bill for their products and services in which you agree and would be financially responsible to pay these vendors directly.

If the patient has provided insurance information, Coastal Primary Care, LLC may, but is not required to assist the patient in the filing of a claim.

I request and authorize that payment of authorized Insurance company benefits may be made on my behalf to Coastal Primary Care for any services furnished to by this company. I authorize any holder of medical information about me to be released to any insurance company(s) any information needed to determine benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/ other insurance company assigned cases, Coastal Primary Care agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

PATIENT SIGNATURE_____ **Date:**_____

RESPONSIBLE PARTY_____ **Date:** _____

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HIPAA

NOTICE OF PRIVACY PRACTICES

In accordance with the law, Coastal Primary Care fully supports and upholds all matters pertaining to the privacy of your protected health care information. We will fully adhere to all legal requirements regarding your protected health care information but reserve the right to change our privacy practices at any time as permitted by the law. If our privacy practices change, we will post a notice in our reception area, and provide you with a copy of the document changes.

CLIENT CONSENT FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I hereby consent to the utilization and disclosure of my protected health information by Coastal Primary Care. In addition, I give my consent to provide treatment and secure payment, and other health care operations as related to my care. I have read/ reviewed the Privacy Practice Statement (as above), prior to signing this consent. I understand that Coastal Primary Care is required by law to report suspected or diagnosed child abuse/neglect; and conditions identified as "reportable conditions" by statue to the State Public Health Office.

Coastal Primary Care may mail to my home, or other designated location, may correspond with me via telephone, leave verbal messages on my voicemail, or speak with me in person, in reference to any items or issues that will assist in the provision of my care, payment, and or other health care operations such as, insurance items, follow-up communication, X-ray and/or laboratory results, or other, pertaining to my care. This includes the transfer of my protected health information (if required) by postal mail, as long as the contents are addressed to me personally and are marked "personal and confidential" or are delivered by Coastal Primary Care.

I further realize that I have the right to request that Coastal Primary Care restrict the use/disclosure of my personal health information regarding treatment, payment, and/or other health care operations or activities. However, Coastal Primary Care is not required to agree to my requested restrictions. If Coastal Primary Care does not agree to my requested restrictions; they are bound by the legal constraints regarding the privacy and protection of my health care information.

I have read and understand the Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information.

Print Name: _____

Signature: _____

Date: _____

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HIPAA CONSENT

I _____, authorize Coastal Primary Care to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance company, and for health care operations like quality reviews. I authorize the persons listed below to give or receive any information via telephone, mail, or in-person which would be of benefit to my care or wellbeing. I am aware that Coastal Primary Care will not be responsible for the handling of any information released to the persons that I have listed below.

NAME:_____ **Relationship:** _____

NAME:_____ **Relationship:** _____

NAME:_____ **Relationship:** _____

NAME:_____ **Relationship:** _____

PATIENT / PARENT / GUARDIAN:

Print Name: _____

Sign Name: _____

Date: _____