Redpoint MEDICAL PSC
128 Southland Dr., Suite 110
Lexington, KY 40503

General Patient Registration

PLEASE PRINT CLEARLY

(STAFF ONLY) COVID SCREENING: _____ Temp: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (month/day/year: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Parent or Legal Guardian Name (if applicable): _____

Primary Language Spoken, if NOT English : _____

Marital Status: ◯ Married ◯ Unmarried Sex: ◯ Male ◯ Female

Spouse Name (if applicable): _____ Spouse Phone: _____

Employer Name (if applicable): _____ Employer Phone: _____

Purpose of Today's Visit: _____

GUARANTOR INFORMATION

If you are here at the request of your employer, and they are handling payment, please skip to Emergency Contact. All others, please complete this section for the Guarantor (person responsible for payment), if it is anyone other than the patient:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (month/day/year: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate Phone Number: _____

EMERGENCY CONTACT INFORMATION

Please check here if your spouse is your primary emergency contact: ◯

For all others, please complete the following primary emergency contact information:

Contact Name: _____ Contact Phone: _____

(please complete the form on back)

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General Patient Consent

CONSENT FOR TREATMENT

I herby voluntarily consent to medical services provided by Redpoint Medical, PSC and its healthcare providers and staff. I understand that these medical services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and tests; prescribed x-rays and other imaging studies; administration of medications; and additional procedures and treatments that may be prescribed by Redpoint Medical PSC's healthcare providers.

I understand that there are certain hazards and risks associated with all forms of treatment, and my consent is given knowing this. I acknowledge that while every effort will be made to keep risks and side effects to a minimum, complications can be unpredictable both in nature and severity, and may occur.

I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such consent.

As part of the medical procedures or tests conducted by Redpoint Medical PSC's healthcare providers and staff, I consent to be tested for human immunodeficiency virus (HIV) infection, hepatitis, or any other bloodborne infectious diseased for purposes directly related to my medical treatment. If a healthcare worker is exposed to my blood or bodily fluids, Redpoint Medical, PSC may, at its cost, test my blood for any infectious disease. Redpoint Medical, PSC shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test was ordered, and b) the results of such tests.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until Redpoint Medical, PSC asks me to complete a new Work Injury Patient Consent form.

I understand that if this consent is being signed on behalf of a minor, this consent is valid until the parent or legal guardian withdraws consent in writing, or until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

COLLECTION OF PAYMENTS

I acknowledge that insurance coverage is an agreement between the insurance carrier and myself. Redpoint Medical, PSC will provide any necessary information to me related to my examinations, injuries, illness, or treatments in order to assist me in making collections from the insurance company. I understand that any amounts authorized by my insurance provider will be paid in the form of direct reimbursement to me, and that I am personally responsible for payment, at the time of service, for all services provided and charged to me. I understand that Redpoint Medical, PSC **DOES NOT** bill my private insurance for service(s) that I receive, and no benefits will be paid from my insurance provider directly to Redpoint Medical, PSC.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

A copy of Redpoint Medical's "Notice of Privacy Practices" has been offered today for my review. I understand The Notice details various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. I acknowledge and consent that Redpoint Medical, PSC may use and disclose my health information for the purposes of treatment, payment, and healthcare operations as outlined in The Notice.

My signature below certifies that: a) the information I have provided on The General Patient Information form (page 1) is correct to the best of my knowledge, and b) I have read and fully understand and consent to each section detailed above in This General Patient Consent form (page 2).

Signature: _____ **Date:** _____