

## General Patient Registration

**PLEASE PRINT CLEARLY**

### 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: \_\_\_\_\_

Email: \_\_\_\_\_

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 (only if here at the request of your employer): \_\_\_\_\_

Employer Phone (only if here at the request of your employer): \_\_\_\_\_

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 only complete this section if SOMEONE OTHER THAN PATIENT (i.e. parent or legal guardian) is responsible for payment. Enter that person's information below.

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)**



128 Southland Dr., Suite 110  
Lexington, KY 40503

# General Patient Consent

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## CONSENT FOR TREATMENT

I hereby 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 diseases 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.

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## COLLECTION OF PAYMENTS

I understand that Redpoint Medical, PSC **WILL NOT** bill any private insurance for service(s) that I receive, and no benefits will be paid from my insurance provider directly to Redpoint Medical, PSC. I understand that any amounts authorized by my insurance provider must 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 acknowledge that insurance coverage is an agreement between the insurance carrier and myself. While Redpoint Medical, PSC will provide necessary information to me related to my examinations, injuries, illness, or treatments in order to assist me in attempting to collect reimbursement from the insurance company, reimbursements are not guaranteed and are often routinely denied for services related to travel. Per USCIS, immigration exams are strictly uninsured.

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## 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. I further acknowledge that if I am here at the request of my employer, results from my visit will be sent to my employer.

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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), and c) I authorize the results from any employer-requested services be shared with my employer.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_