Richard D. Orgill, M.D.

Patient Registration Form

Patient Information:			
Last Name:	First Name:	MI:	Acct #:
Mailing Address:	City, State, Zip:	Home Phone: Cell Phone:	
Date of Birth:	SSN:	Marital Status:	Sex: (M/F)

Date of Birth:	SSN:	Marital Status:	Sex: (M/F)	Referring Physician:

Employer: Employer Phone #:	**Meaningful Use Verification:** Preferred Language ______________________________ **Race:** ☐ White ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino ☐ Asian ☐ Other Race
Email Address:	

Responsible Party(person signing): *** Minors *CANNOT* be listed as responsible party.*** **Persons over 18 years of age will be listed as SELF for responsible party.**		
Name:	Employer:	Date of Birth:
Mailing Address:	City, State, Zip:	Phone: SSN:

Primary Insurance:			
Name & Phone number of Insurance:	Insurance ID Number:		
Insurance Address:	Group #:		
Policy Holder Information:			
Name (Last, First, MI):	Relationship to Subscriber:	Phone #:	
Subscriber SSN:	Sex (M/F):	Date of Birth:	Employer:
Secondary Insurance:			
Name & Phone Number Of Insurance:	Insurance ID Number:		
Insurance Address:	Group #:		
Policy Holder Information:			
Name (Last, First, MI):	Relationship to Subscriber:	Phone #:	
Subscriber SSN:	Sex (M/F):	Date of Birth:	Employer:
Any Additional Insurance:			
Name & Phone Number of Insurance: Name of Policy Holder:	Insurance ID Number: Group :		

Emergency Contact: NOT AT THE SAME ADDRESS AS PATIENT		
Name:	Phone #:	Relationship:
Address:	City, State, Zip:	

All charges are due at the time of service. All services rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. Therefore I hereby authorize Dr. Orgill to furnish all information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I assign to the physician(s) all payments for medical services rendered to myself.

Signature: ____ Date:______________________________

Patient/Family History

List your current physician(s):____ Phone:___________________________

HAVE YOU HAD OR DO YOU HAVE:

Yes	No	Heart Trouble
Yes	No	High Blood Pressure
Yes	No	Epilepsy
Yes	No	Seizures or Stroke
Yes	No	Jaundice
Yes	No	Hepatitis
Yes	No	Mononucleosis
Yes	No	Emphysema
Yes	No	Bronchitis
Yes	No	False or Loose Teeth
Yes	No	Dental Caps or Bridges
Yes	No	Chest X-Ray in past year
Yes	No	Electrocardiogram in past year
Yes	No	Glaucoma
Yes	No	Abnormal Bleeding Tendencies
Yes	No	Anticoagulant Therapy (blood thinners)
Yes	No	Blood Disease
Yes	No	Kidney Disease
Yes	No	Fracture of Facial Bones
Yes	No	Fracture of Neck or Back
Yes	No	Muscle Weakness
Yes	No	Back Trouble
Yes	No	Paralysis
Yes	No	Blood Transfusion
Yes	No	A Positive AIDS Blood Test
Yes	No	Blood Vessel Disease
Yes	No	Arthritis
Yes	No	Psychiatric or Mental Disorders
Yes	No	Diabetes
Yes	No	Thyroid Disease
Yes	No	Allergy Tests
Yes	No	Asthma

PREVIOUS ANESTHETIC HISTORY:

Date of last anesthetic:___________________________

Any Abnormal reactions: Yes No

Relatives with abnormal reaction: Yes No

COMMENTS:___________________________________

____

____

LIST PREVIOUS SURGERIES (Type): NONE

____

____

____

____

LIST MEDICATIONS PRESENTLY TAKING: NONE

____

____

____

____

NON PRESCRIPTION:___________________________

____

____

LIST ALLERGIES (Medical): NONE

____

____

____

____

IF FEMALE OR CHILD BEARING AGE:

Are you pregnant: Yes No

Pharmacy name, address, and phone number: ____

____

Other medical problems, illnesses, or hospitalizations (please list): NONE

____

____

List any medical problems that run in your family members: NONE

____

____

DO YOU:

Wear contact lenses	Yes	No
Smoke (pkg/day)	Yes	No
If former smoker, how long? _________		
Drink alcoholic beverages	Yes	No
Take drugs not prescribed	Yes	No

If needed, do you object to blood transfusions to save your life:

Yes No

Age:__________

Current Weight:____________________

Current: Height: ____________________

____

Patient Name

___________________________Date: _______________

Parent/Guardian Signature

Symptoms

Please circle any of the following symptoms you are currently experiencing.

If a symptom is not listed, please write it below.

Constitutional:
- fever
- chills
- weight loss
- malaise/fatigue

HEENT:
- tinnitus (ringing in ears)
- hearing loss
- ear pain
- ear drainage/bleeding
- congestion
- sore throat
- hoarse
- neck pain

Eyes:
- blurred vision
- double vision
- photophobia
- pain
- discharge
- redness

Respiratory:
- cough
- bloody cough
- sputum production
- shortness of breath
- wheezing

Cardiovascular:
- chest pain
- palpitations
- leg swelling

Gastrointestinal:
- heartburn
- reflux
- nausea vomiting
- abdominal pain
- diarrhea
- constipation
- blood in stool

Genitourinary:
- dysuria (pain with urination)
- urgency
- frequency
- blood in urine
- flank pain

Neurological:
- dizziness
- tingling
- tremors
- sensory changes
- focal weakness
- seizures
- loss of consciousness
- weakness
- headaches

Endo/Heme/Allergies:
- inappropriately cold/hot
- bleeding
- bruising
- pale
- environmental allergies
  - nose
  - eyes
  - skin
  - lungs
  - GI

Psychiatric/Behavioral
- depression
- nervous/anxious
- insomnia
- suicidal
- hallucinations
- memory loss
- substance abuse/dependency

Patient Name:____ Date:________________________

Physician that referred you: ____

Thank you for choosing us as your health care provider. The physician and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the Patient Registration Form before seeing your physician.

Dr. Orgill is committed to providing you with the best possible healthcare. In order to fully assess your medical condition during your examination, additional tests or procedures may be required (i.e. hearing test, allergy test or scope).

- ***These additional tests or procedures may result in additional charges.***

Insured Patients

All co-pays and co-insurance are due at time of service. If you have a deductible, you are responsible for all charges until the deductible is met. You are responsible for any and all allowable charges which remain after your insurance has paid. Balances are due within thirty (30) days of the billing statement date. The only exception will be if arrangements with the billing office have been made prior to your visit. Any balance unpaid after 60 (sixty) days will be sent to a collection agency.

Your insurance policy is a contract between you, your employer, and your insurance company .Dr. Orgill is not a party to that contract. Knowledge of your insurance policy is your responsibility. Not all services are covered by all carriers. Services which are not covered by your insurance will be billed to you. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance; therefore you are ultimately financially responsible for payment of services rendered.

If your insurance carrier has a "network" of providers, it is your responsibility to ensure we are an "in network" provider prior to obtaining services. If we are a provider on your plan we will bill your insurance carrier for you.

If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible will be greater.

An authorization or referral may also be required. It is your responsibility to make sure we have this authorization ***prior*** to your appointment. It is the patient's responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

Patient Responsibilities

- Obtain authorization/referral prior to appointment (if required)
- Pay all co-pays and co-insurance at time of service
- **Ensure insurance carrier information and patient information is accurate. If a claim is denied because of incorrect insurance or patient information, you will be responsible for the balance.**
- Be aware of your plan benefits and inform us of any restrictions that your plan might have
- Contact your insurance carrier if your claim has not been processed within 45 days
- Payment of statement in full at time of receipt
- Non-Insured patients make payment in full at time of service
- Payment of $35.00 return check fee if your check is not honored by your financial institution
- **Ensure that the "Responsible Party" section of the Patient Registration Form is completed with the address that billing statements should be mailed to.**
- **Cancel or reschedule appointments 24 hours prior to your appointment time or a cancellation fee will be charged.**
- **Arrive on time for your scheduled appointment. Arriving 15 minutes or later than your scheduled appointment time will result in the appointment(s) being cancelled or rescheduled and a cancellation fee charged.**

We accept checks, Visa, MasterCard, and Discover.

Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to contact our billing office at (405) 605-4368.

____ _________________________

Patient/Guardian Signature Date

HIPAA Release

I, __________________________, give Dr. Orgill or his staff permission to discuss my medical treatment/condition, medication or any otherwise confidential medical information with:

Name (please print)	Relationship
Name (please print)	Relationship
Name (please print)	Relationship

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICALINFORMATION ABOUT YOU MAY BE USED ANDDISCLOSED AND HOW YOU CAN GET ACCESS TOTHIS INFORMATION. PLEASE REVIEW ITCAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUTTHIS NOTICE, PLEASE CONTACT OUR RECEPTIONIST IMMEDIATELY.

WHO WILL FOLLOW THIS NOTICE

This notice describes our office's practices and that of:

- All employees, staff and other personnel
- Any health care professional authorized to enter information into your file or record

Effective April 14, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health ispersonal. We are committed to protecting medical information about you.We create a record of the treatment, care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. We refer to this record of care and services as "Protected Medical Information". This Notice applies to all of the Protected Medical Information. This Notice will tell you about the ways in which we may use and disclose Protected Medical Information about you. We are required to:

- Make sure that Protected Medical Information that identifies you is kept private and is only disclosed in a manner permitted by the Health Insurance Portability and Accountability Act ("HIPAA").
- Follow the terms of the Notice that is currently in effect.
- Give you this Notice of our legal duties and privacy practices with respect to Protected Medical Information about you.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose Protected Medical Information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose Protected Medical Information will fall within one of the categories.

For Treatment: We may use Protected Medical Information about you to provide you with medical treatment, care or services. We may disclose Protected Medical Information about you to doctors, nurses, technicians, medical students, pharmacists or other personnel who are involved in your care. Different departments or areas of our practice also may share Protected Medical Information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose Protected Medical Information about you to people outside the practice who may be involved in your medical treatment orcare, such as family members or others we use to provide services that are part of your care.

For Payment: We may use and disclose Protected Medical Information about you so that the treatment, care and services you receive may be billed to and payment may be collected for you from an insurance company or a third party. For example, we may need to give the Protected Medical Information about the treatment you received to your health plan, so that your health plan will pay us or reimburse you. We may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may use and disclose your Protected Medical Information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your protected medical Information to bill you directly for services and items.

Appointment Reminders: We may use and disclose protected medical Information to contact you as a reminder that you have an appointment for treatment, care or services.

Treatment Alternatives: We may use and disclose Protected Medical Information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical Information to tell you about health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release Protected Medical Information about you to a designated friend or family member who is involved in your medical treatment or care. We may give Protected Medical Information to someone who helps pay for your treatment or care. In addition, we may disclose Protected Medical Information about you to an entity assisting in a disaster relief effort, so that your family may be notified about your condition, status or location.

Research: Under certain circumstances, we may use and disclose protected medical Information about you for research purposes. All research projects are subject to a special approval process. The process evaluates a proposed research project and its use of your Protected Medical Information, trying to balance the research needs with the patient's rights of privacy of the Protected Medical Information. However, we may disclose protected medical Information about you to people preparing to conduct research project, though we will ask for your specific permission to give are searcher your name, address or other information that reveals your identity. In rare cases, your permission may be waived as directed by federal, state and local news.

As Required by Law: We will disclose Protected Medical Information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may need to use and disclose Protected Medical Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL SITUATIONS

Organ and Tissue Donations: If you are an organ donor, we may release Protected Medical Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Protected Medical Information about you as required by military command authorities. We may also release Protected Medical Information to a foreign military authority, if you are in their service.

Worker's Compensation: We may release Protected Medical Information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness. State and/or federal law control release of such information.

Public Health Risks: We may disclose Protected Medical Information about you for public health activities. These activities include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report a known or suspected crime
- To report child abuse or neglect
- To report vulnerable adult abuse
- To report reactions to medications or problems with products
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required or authorized by law

Health Oversight Activities: We may disclose Protected Medical Information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Protected Medical Information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Protected Health Information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About a death we believe may be the result of criminal conduct
- About criminal conduct involving our practice
- About the victim of a crime, if we are unable to obtain the person's agreement
- In emergency circumstances to report a crime, the location of the crime or victims and/or the identity, description or location of the person who committed the crime

Medical Examiners and Funeral Directors: We may release Protected Medical Information to a medical examiner. This may be necessary to indentify a deceased person or to determine the cause of death. We may also release Protected Medical Information about patients to funeral Directors as necessary to carry out their duties.

National Security, Intelligence and Federal Protective Activities: We may also release Protected Medical Information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may release Protected Medical Information to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state and/or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Protected Medical Information about you to the correctional institution or law enforcement official. The release of this information would be necessary for this practice to provide you with healthcare, to protect your health and safety or the health and safety of others and for the security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding Protected Medical Information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy Protected Medical Information that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes. To inspect and/or copy your Protected Medical Information you must submit your request to release information in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. By Oklahoma Statute, we may charge you $0.25 per page for copies, plus our postage costs. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you $5.00 per image.

Right to Amend: If you feel that Protected Medical Information we have about you is incorrect or incomplete, you may ask us to amend the incorrect information. You have the right to request an amendment for as long as the Protected Medical Information is kept by our practice. ‘To request an amendment, your request must be made in writing and submitted to the medical records office. In addition, you must provide a reason that supports your amendment request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the Protected Medical Information kept by our practice
- Is not part of the Protected Medical Information which you would be permitted to inspect or copy
- In our judgment is accurate and complete as it appears
- Was not created by us, unless the person or entity that created the Protected Medical Information is no longer available to make the amendment.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we have made of your Protected Medical Information. You must submit the request of this list of disclosures, in writing to our office. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. The first list you request within each 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may chose to withdraw or modify your request at that time, before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction disclose about you for treatment, care, payment or health care operations. We must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your Protected Medical Information for treatment, care, payment or health care operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship. You have the right to request a limit on the Protected Medical Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose Protected Medical Information about a surgery to your family. We are not required to agree to your request. If we do not agree, we will comply with your request unless the Protected Medical Information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the receptionist in our office. In your request, you must tell us what information you want to limit, whether you want to limit our use and/or disclosure and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone or by e-mail. To request confidential communications, you must make your request in writing to the receptionist in our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Copy of this Notice: You have the right to a copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the content of this Notice. We reserve the right to make the revised or changed notice effective for Protected Medical Information we already have about you as well as any protected medical Information we receive in the future. We will post a copy of the current Notice in our office. The Notice will contain on the first page, in the top right hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact the Office Manager at (405) 605-4368. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF PROTECTED MEDICALINFORMATION

Other uses and disclosures of Protected Medical Information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose Protected Medical Information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose Protected Medical Information about you for the reasons covered by your written authorization. You understand and acknowledge that we are unable to take or retrieve any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Richard D. Orgill, M.D., P.C.
A Professional Corporation

I hereby acknowledge a receipt of a copy of the Notice of Privacy Practices containing a full description of my rights under the Health Insurance Portability and Accountability Act (“HIPAA”).

____

Printed Name

____

Signature   Date