PLEASE PRINT CLEARLY	☐ New Patient Re	egistration 🗆 Pat	tient Information Update	
Legal Name:First	Middle Initial	Last	·	
Date of Birth:/ Se	x:		Pref. Language:	
Street Address:	·			
City:	State:	Zip:		
Tele #: Home:	Work:	Cell:		
Marital Status: S M W Sep D	Race:	Ethnicity	y: Hispanic or Non Hispanic	
Email Address:		Spouse's Name:	·	
Emergency Contact:	Tel	e #:	Relationship:	
Patient Employer Informatio	<u>n:</u>		· · · · · · · · · · · · · · · · · · ·	
Name:	Tele #:		Occupation:	
Street Address:		City:	State:Zip:	
Insured Person (if NOT paties	<u>nt):</u>			
Name:	Tele #:		Date of Birth:/	
Email Address:			SSN#:	
Relationship to patient:Spouse	Dependent	Parent/Guardian		
 I hereby authorize this organizati from my insurance company be r I certify the information I have re 	l information necessary to pon to apply for benefits on nade directly to Haller & Hu ported with regard to my in	my behalf for covered servic ag P.C. (or to the party who a asurance coverage is correct		
Date: Signature	2:			
Patient Consent:		(Patient, Parent, or Guar	rdian)	
I understand, under the Health Insurance Pounderstand this information can and will be Conduct, plan and direct my trea Obtain payment from third-party Conduct normal health care oper I have been informed by you of your Notice been given the right to review such Notice of	used to: tment and follow-up among payers. ations such as quality asses of Privacy Practices contain f Privacy Practices prior to:	g multiple health care provid sments and physician certifi ing a more complete descrip signing this consent. I unders	ertain rights regarding my protected health information. I ders who may be involved in the treatment directly or indirect ications. I of the uses and disclosures of my health information. I histand that this organization has the right to change its Notice of at the address below to obtain a current copy of the Notice of	ave of
I understand I may request in writing you re understand you are not required to agree to			o carry out treatment, payment or health care operations. I all u are bound to abide by such restrictions.	lso
I understand that I may revoke this consent	in writing at any time, exce	pt to the extent that you hav	ve takeп action relying on this consent.	
Patient Name:PI	ease Print	Relatio	onship to Patient:SelfSpouseParent/Gua	ardian

Haller & Hug, P.C.

HIPAA Message Authorization

In general, the HIPAA privacy law gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications and to specify by what means communications will be made.

I wish to be contacted in the following manner (please <u>r</u> a selection under the option).	number in order of preference and make
Home phone #	
Okay to leave a message with detailed info	
Leave a message with a call-back number only	
Cell phone #	
Okay to leave a message with detailed info	
Leave a message with a call-back number only	
Patient Portal Message – Can be accessed via our webs	ite hallerandhug.com from any computer.
You can use your existing login and password from yahoo, n with the FMH option. Once connected you can follow the direction simply add the connection to our office under the account tal smartphone/iphone you can download the free app with the lof the above login options does <u>NOT</u> in any way connect you above listed websites)	rections in the invite you receive via email, or o in your connections. To use this from a inks on our website. (Please note using one
Please list email for invite if not already a member_	
Written Communication	•
Okay to mail to my house address	
Okay to fax to this number	<u>—</u>
Patient/Guardian Signature:	Date:
Patient Name:	DOB:
(Please print)	

A Patient-Centered Medical Home is a Partnership Between the Patient and his/her Physicians

Being a part of a Patient-Centered Medical Home, your Primary Care Physician will:

- Work with you to improve your health
- Review your medications at every visit and recommend changes if needed
- Develop a plan with you to improve your health and manage any chronic health problems
- Set health goals with you and monitor your progress to help you stay healthy
- Use computer technology as needed to optimize your care
- Inform you of all test results in a timely manner
- Provide you with educational material and information about community programs that will help you improve your health
- Provide 24 hour phone access to a medically trained professional (doctor, nurse or other provider)
- Work with after-hours care centers to be informed of your visit within 24 hours
- Offer same day appointments when needed

By choosing to participate in a Patient-Centered Medical Home, I agree to:

- Make sure my doctor knows my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Follow my doctor's recommendations
- Frequently sign into my patient medical record portal to update my medical history, review messages, and communicate with my provider(s) when necessary
- Ask my doctor questions about things I do not understand
- Ask my Primary Care Physician for advice before making an appointment with a specialist
- Ask other health care providers to send my doctor information such as lab or test results, x-rays, or treatment notes
- Understand my insurance, what it covers and update the office with changes
- Provide the office feedback on how they can improve my care

| Not at this time thanks

Being a part of a Patient-Centered Medical Home Neighborhood, your Specialists will:

- Communicate with your Primary Care Physician about treatment plans, medications, test orders and test results
- Support the treatment plans and health goals set by your Primary Care Physician
- Have an agreement with your Primary Care Physician regarding who will have the lead responsibility for your care if a chronic disease exists
- Have same day appointments available for urgent problems and appointments within 1-3 weeks available depending on your medical needs
- Work with your Primary Care Physician to coordinate all aspects of your care

I would like to be a part of the Haller & Hug,
PC PCMH family and agree to do my part in
making me as healthy as possible.

Patient Signature:		ר מווסות ואמווס.
--------------------	--	------------------