Colleen Campbell, M.D.

5503 East Busch Blvd
Temple Terrace, FL 33617
(813) 200-7717 Phone
(813) 985-8500 Fax

3105 North 22nd Street
Tampa, FL 33605
(813) 200-7717 Phone
(813) 985-8500 Fax

PATIENT REGISTRATION FORM

General:

Name: First_____Middle _____Last_____

SSN:_____D.O.B._____Gender_____AKA_____

Permanent Home Address & Phone:

Street_____Zip:_____

Ph (H):_____(W):_____(Cell)_____

Specify Your Preferred Phone #:_____

Email:_____

Mailing Address (If same as above, put "Same"):

_____Zip:_____

Race:_____Sex: (Male/Female) Marital Status:_____

Highest Education Level Achieved:_____Place Of Employment:_____

Driver's License # & State Issued:_____

Pharmacy Name:_____Pharmacy Address:_____

Pharmacy Ph #:_____Fax #:_____Who Referred You:_____

Emergency Contact:

Contact Name:_____Relationship:_____

Address of Contact:_____

Phone: (H)_____(W)_____(Cell)_____

Do you have Medical Insurance? _____If No, then stop here.**********

Health Insurance Information:

Primary Person Insured:_____Relationship to Patient:_____

Address & Ph # of Insured:_____

SS # of Insured:_____DOB_____Place of Employment:_____

Name of Insurance:_____

Claims Address:_____

Policy ID#: _____Group Name:_____Group #:_____

If Medicare is Your Primary:

Write your Medicare # (Include the letters):_____

If you are employed, State Where:_____Ph#:_____

Primary Insurance is:_____

Secondary Insurance:_____

Tertiary Insurance:_____

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PERMISSION FOR TREATMENT

I hereby give Dr. Campbell and all associated healthcare personnel, permission to provide medical treatment as necessary.

STATEMENT OF FINANCIAL RESPONSIBILITY

Dr. Campbell may bill my insurance company and/Medicare for services provided to me; and as such, Dr. Campbell may release my personal health information for processing of such claims. Therefore, I will provide complete, correct and current insurance information at every office visit or when any changes occur.

It is my responsibility to be familiar with all the services covered by my insurance plan and I will pay to Dr. Campbell the fees and costs, including deductibles and co-payments, not covered by the plan.

I understand that Dr. Campbell will make every effort to bill and recover payment on my behalf; however, the ultimate responsibility for payment of rendered services is mine. Any unpaid balance is due within thirty (30) days of receiving statement.

I HAVE RECEIVED THE PATIENT RIGHTS AND RESPONSIBILITIES FORM (see form)

NOTICE OF PRIVACY PRACTICES

Representatives of Dr. Campbell have provided me with its Notice of Privacy Practices which describes how she utilizes and discloses "Protected Health Information". I understand that I may review this document before signing this form. The terms of The Notice of Privacy Practices may be changed at any time but patient may obtain a copy of the revised notice from the office manager upon request.

I give my consent to release my Protected Health Information to the following individual(s):

(1) _____

(2) _____

Print Patient's Name: _____ D.O.B: _____

Patient's or Guardian's Signature: _____

Relationship to Patient: _____

Date: _____

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Patient Rights and Responsibilities

Dr. Campbell, is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

1. A personal clinician who will see you on an on-going, regular basis.
2. Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
3. A second medical opinion from the clinician of your choice, at your expense.
4. A complete, easily understandable explanation of your condition, treatment and chances for recovery.
5. The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
6. Confidential management of communication and records pertaining to your medical care.
7. Information about the medical consequences of exercising your right to refuse treatment.
8. The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
9. Be free from mental, physical and sexual abuse.
10. Humane treatment in the least restrictive manner appropriate for treatment needs.
11. An individualized treatment plan.
12. An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
13. The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
14. The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

1. Knowing your health care clinician's name and title.
2. Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
3. Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
4. Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
5. Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.

Name: _____ Date: _____

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Patient Rights and Responsibilities Cont.

6. Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
7. Telling your clinician about any changes in your condition or reactions to medications or treatment.

8. Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.

9. Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
10. Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
11. Paying co-payments at the time of the visit or other bills upon receipt.
12. Following the office's rules about patient conduct; for example, there is no smoking in our office.
13. Respecting the rights and property of our staff and other persons in the office.

PLEASE SIGN THAT YOU HAVE READ & UNDERSTAND THE ABOVE:

NAME: _____ D.O.B: _____

SIGNATURE: _____

DATE: _____