MRE Family Care Clinic
404. E. Bloomington St, Iowa City, IA 52245
P: 319.351.1483 F: 319-351-1027
mrefamilycare.com

Patient Registration Form:

Patient Information:

First Name: _____ **M.I.** _____ **Last Name**: _____
Maiden Name: _____ **Sex:** Male Female **Pronouns:** He/Him She/Her They/Them
Date of Birth: _____ **SSN:**_____
Marital Status: Single Married Divorced Widowed Separated **Spouse Name:** _____
Race: _____ **Ethnicity:** _____
Address Line 1: _____ **Phone:** _____
Address Line 2: _____ **Ok to receive texts:** Yes No
City: _____ **Ok to leave voicemail?** Yes No
State: _____ **Zip:** _____ **Email:** _____

Emergency Contact Information: For minors/dependent adults please provide a contact outside parent/guardian.

Name: _____ **Relationship:** _____ **Phone:** _____

Employment Information: *Adult patients only fill out this section*

Patient Employment Status: Employed Un-employed Student Retired Disabled Child
Patient Employer Name: _____ **Employer Phone:** _____
Spouse Employment Status: Employed Un-employed Student Retired Disabled Child
Spouse Employer Name: _____ **Employer Phone:** _____

Insurance Policy Information:

Primary:
Carrier: Medicaid Medicare Medicare Adv. BCBS United Aetna Cigna Other: _____
Full name of policy holder: _____ **Policy Holder DOB:** _____
Relationship to patient: Self Spouse Child Other

Secondary:
Carrier: Medicaid Medicare Medicare Adv. BCBS United Aetna Cigna Other: _____
Full name of policy holder: _____ **Policy Holder DOB:** _____
Relationship to patient: Self Spouse Child Other

Authorization: *Optional for Adult patients.*

By providing this authorization release my Personal Health Information (PHI) to the following individual(s), I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I also may refuse to sign this authorization and my treatment and/or payment obligation with not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy rules. I understand that I may revoke this authorization at any time by notifying MRE Family Care Clinic in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. I hereby authorize MRE Family Care Clinic to use and disclose health information to the following:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/hers assistance. I acknowledge that no guarantees have been made as to the effect of such treatment.

Signed: _____ **Relationship**: _____ **Date**: _____

I have reviewed the MRE Family Care Clinic Notice of Privacy Practices and understand I may request a copy at any time.

Signed: _____ **Relationship**: _____ **Date**: _____

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Parents of Minor Children and Legal Guardians:

Parent/Guardian Information: ***Only include legal parents/Guardians in this section***

Parent 1: **Financially Responsible Party?** Yes No

First Name:_____ **M.I.** _____ **Last Name:** _____

Date of Birth: _____ **SSN:**_____ **Relationship to Pt.** _____

Address Line 1: _____ **Phone:** _____

Address Line 2: _____ **Ok to receive texts:** Yes No

City: _____ **Ok to leave voicemail?** Yes No

State: _____ **Zip:** _____ **Email:** _____

Parent 1 Employment Status: Employed Un-employed Student Retired Disabled Child

Parent 1 Employer Name: _____ **Employer Phone:** _____

Parent 2: **Financially Responsible Party?** Yes No

First Name:_____ **M.I.** _____ **Last Name:** _____

Date of Birth: _____ **SSN:**_____ **Relationship to Pt.** _____

Address same as Parent 1? Yes No ***If no please fill out below.***

Address Line 1: _____ **Phone:** _____

Address Line 2: _____ **Ok to receive texts:** Yes No

City: _____ **Ok to leave voicemail?** Yes No

State: _____ **Zip:** _____ **Email:** _____

Parent 2 Employment Status: Employed Un-employed Student Retired Disabled Child

Parent 2 Employer Name: _____ **Employer Phone:** _____

Legal Documentation

Minor Children: Are there any court ordered restraining orders or court ordered custody agreements in place for this child that affect medical decision making that we need to be aware of? Yes No

If yes: Persons authorized to make medical decisions: _____

Please provide us a copy of the legal paperwork that demonstrates this determination.

Dependent Adults: Please provide guardianship documentation to keep on file for this patient.

Other Persons Authorized to attend child/dependent visits: *(Step-parents, grandparents, Siblings, etc.).*

I, _____ **parent/guardian of:** _____ **(Childs name), DOB** _____ do hereby authorize the following individuals to accompany my child/dependent to medical appointments. I consent that only parents/guardians listed above and those listed below are granted authority to authorize treatment. I also authorize treatment of my teen age 16 and above, in my absence. Authorized individuals include:

First Name: _____ **M.I.** _____ **Last Name**: _____

Phone: _____ **Relationship to patient** :_____

First Name: _____ **M.I.** _____ **Last Name**: _____

Phone: _____ **Relationship to patient** :_____

The information provided above is correct and complete the best of my ability. I have provided all information that maybe needed to provide my children/dependent with the best care possible.

Signed: _____ **Relationship**: _____ **Date**: _____

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Office Policy Acknowledgement:

Please initial in the space provided next to each policy.

Patient Name: _____ D.O.B._____ Date:_____

_____ I understand that access to providers is available Monday- Friday 8:00am - 5:00pm at MRE Family Care Clinic via phone 319-351-1483.

_____ I vow that I will only contact providers outside of business hours for emergent questions. If advice is needed for an urgent matter outside of business hours I will contact the UIHC Medical Campus Downtown Operator at 319-339-0300, and have them contact the on call provider.

_____ I understand that if I contact the on-call provider outside of business hours they are not obligated to provide treatment over the phone. They may refer me to urgent care, quick care, emergency department, or may encourage me to schedule an appointment the next business day.

_____ I will not contact or approach providers outside of the office environment to discuss medical issues. This includes discussing medical concerns via social media, text message, or in public settings such as stores or malls.

_____ I will be responsible for monitoring my own prescriptions and refills. I will request refills at least 72 hours in advance. If I do not provide advance notice I understand that I could be left without medications.

_____ MRE Family Care Clinic has a strict policy on scheduled medications (ie. Narcotics, Sedatives, and Stimulants). If you require these medications you will be required to sign a Controlled Substance Contract and designate one pharmacy to which these prescriptions will be sent.

_____ No show or cancellations made less than 24 hours in advance are subject to a $25 fee.This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. 3 no-shows may result in discharge from our clinic.

_____ If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule. We schedule our appointments to allow each patient to receive adequate time and attention of our staff and providers, late arrivals causes schedule disturbances the remainder of the day.

_____ I will not expect staff and providers to “fit in” additional family members or friends into my scheduled appointment time. I will not expect providers to see me for issues if I am scheduled for a nurse only visit (lab draw/ immunization appointment).

_____ I agree to pay co-payments and outstanding balances at the beginning of each appointment. If there is a balance more than 120 days old the balance may be sent to collections. My patient account will be placed on hold and no further visits will be allowed until balance is paid, or payment plan is established.

_____ It is my responsibility to inform MRE Family Care Clinic of any changes to name, address, phone number, and insurance. I understand that insurance policy’s require “timely filling” if I do not provide this information during my visit, and in a timely manner, I am responsible for payment in full for all services rendered.

_____ I understand that it is my responsibility to verify that the provider I am seeing is within my insurance network. Any financial portion that is deemed “member responsibility” such as co-pay, deductible, or non-covered services are my responsibility to pay in a timely manner.

_____ I will treat all persons within MRE Family Care Clinic with respect and kindness. Verbal and physical abuse or aggression will not be tolerated. Outbursts against staff will result in immediate discharge from MRE Family Care Clinic.

_____ I understand that forms that need filled out (FMLA, Disability, Travel, etc) will be provided with a minimum of 1 weeks allowance for submission. If forms are provided outside of a scheduled appointment I will be charged a $35 fee not payable by insurance company.

_____ I understand that I maybe “double billed” for wellness exams if new medical issues, treatments, or testing is preformed/discussed, or if extensive time is spent with provider during visit. I understand that I am responsible for the remaining balance.

I understand that failure to follow these policies may result in discharge from MRE Family Care Clinic.

Signature: _____ Relationship: _____ Date: _____