St. Clair Health

St. Clair Medical Group

Please complete the forms attached and return to the Bethel Park office prior to your scheduled appointment date/time.

To return, you may either fax to 412-942-7889 or mail / drop off at the address listed below.

Thank you for your cooperation!

Ripepi Surgical Associates

2000 Oxford Drive, Suite 216

Bethel Park, PA 15102

St. Clair Health
St. Clair Medical Group

Today's Date: _____

New Patient Registration Form

Patient Demographic Information

Full Legal Name: _____
Last First Middle

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Other _____
MM / DD / YYYY *Please Specify*

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated **Please Address As:** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Race/Ethnicity: ☐ AmerIndian/Alaskan ☐ Asian ☐ Black/AfricanAmer ☐ Hawaii/PacificIsland ☐ Hispanic/Latino ☐ Not Disclosed ☐ Unknown ☐ White

Address: _____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Email Address: _____

Employment: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Student Full-Time ☐ Student Part-Time

Employer: _____ **Occupation:** _____

Emergency Contact: _____
Name Relation Phone Number

If Minor, Parent / Guardian: _____
Name Relation Phone Number

Primary Insurance	**Secondary Insurance (If applicable)**
Insurance Company:_____	**Insurance Company:**_____
Policy Holder Name _____	Policy Holder Name _____
ID# _____ Group # _____	ID# _____ Group # _____
Address _____	Address _____
Phone # _____	Phone # _____
DOB _____ SS# [optional]_____	DOB _____ SS# [optional]_____
Relationship to Patient _____	Relationship to Patient _____

Workers Compensation/Auto (if applicable)

Name of Insurance Company _____ Phone # _____ Fax # _____
Claim # _____ Date of Injury _____ SS# [optional]_____
Billing Address _____
Adjuster Name _____ Phone # _____
Employer Contact _____ Phone # _____

St. Clair Health

St. Clair Medical Group

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other heal th plan benefits to the St. Clair Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on my behalf to St. Clair Medical Group for healthcare services furnished. I authorize any holder of medical information about me to release to HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information needed to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Patient or if a minor, Responsible Party

Date

St. Clair Health
St. Clair Medical Group

St. Clair Medical Group Policies & HIPAA

*Welcome to **St. Clair Medical Group** and thank you for choosing us as your healthcare provider. We would like to take this opportunity to advise you of our practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.*

NOTICE OF PRIVACY PRACTICES

We value our patients' rights to privacy in regard to their health information. Please take a moment to review our Notice of Privacy, which provides a complete description of permitted uses and disclosures of healthcare information.

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I wish to allow disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

NAME	RELATIONSHIP	PHONE NUMBER	DISCLOSURE	LIMITATIONS
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	
			☐ FULL ☐ LIMITED	

In the event that we need to contact you, are we permitted to leave a message on your answering machine? ☐ Yes ☐ No

In case of an emergency, may we contact an individual listed above *(marked as "full" disclosure)?* ☐ Yes ☐ No

ST. CLAIR MEDICAL GROUP POLICIES

- You are responsible for notifying us of any changes to your address, personal information, or insurance information.
- **St. Clair Medical Group** is pleased to process your insurance claim for reimbursement. However, please remember that:
  - You must present your insurance card and photo ID at each visit.
  - Your insurance is a contract between you, your employer, and the insurance company. **St Clair Medical Group** is not a party to your health insurance contract.
  - Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
- All copayments are to be paid in full at the time of service.
- If you do not have health insurance coverage or do not bring proof of health insurance coverage to each visit, payment in full will be due at the time of your visit.
- We accept payments in the form of cash, personal check, and most major credit cards. However, we **do not accept Care Credit.** If you are in need of financial assistance, please review St. Clair Medical Group policy on https://www.stclair.org/billing-insurance/financial-assistance/
- **St. Clair Medical Group** and/or agencies working on St Clair Medical Service's behalf may need to contact patient or guarantor via land phone line or cell phone regarding balance due for services.
- Out of consideration to our other patients, if you arrive more than 15 minutes late to your appointment, there may be a delay in your visit, or you may be asked to reschedule your appointment.
- Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least **24 hours in advance** to reschedule.
- **St. Clair Medical Group** requests previous medical records so that we may have the best understanding of your medical history.

PATIENT ACKNOWLEDGEMENT

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the Notice of Privacy Practices.

_____ _____ _____

Patient Name (PRINTED) **Signature of Patient or Responsible Party, if a Minor** **Date**

FOR OFFICE USE ONLY
A good faith effort was used to obtain written acknowledgement of the Notice of Privacy Practices on:
Office Staff Name (PRINTED):_____ Office Staff Signature _____ Date:_____

St. Clair Health

St. Clair Medical Group

(412)942-7880 PHONE (412)942-7889 FAX

Name _____

DOB _____

Height _____ Weight _____

PCP _____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER PRODUCTS)	ALLERGIES (PLEASE MARK NONE IF NO ALLERGIES)
MEDICAL HISTORY (PLEASE MARK NONE IF NO MEDICAL HISTORY)	SURGICAL HISTORY (PLEASE MARK NONE IF NO SURGICAL HISTORY)
FAMILY HISTORY CANCER YES NO DIABETES YES NO VASCULAR DISEASE YES NO BLOOD CLOTS YES NO **ANTONIO RIPEPI MD**	SOCIAL HISTORY TOBACCO YES NO TYPE AMOUNT ALCOHOL YES NO TYPE AMOUNT TYPE OF JOB OTHER

Signature _____ Date_____

St. Clair Health
St. Clair Medical Group

Today's Date: _____

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature is REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ _____ _____ **Date of Birth:** _____
(LAST) (FIRST) (M.I.)

Address:

_____
STREET APT #

_____
CITY STATE ZIP CODE

Phone Number: _____
Please circle preferred: HOME CELL WORK

Use and Disclosure of Protected Health Information

Ripepi Surgical Associates is authorized to (circle one): **SEND** *OR* **RECEIVE**

Practice Address: **2000 Oxford Drive, Suite 216 Bethel Park, PA 15102**

Phone Number: **412-942-7880** *Fax Number:* **412-942-7889**

_____ is authorized to (circle one): **SEND** *OR* **RECEIVE**
(PERSON(S) / ORGANIZATION(S))

Practice Address: _____
(STREET) (SUITE #) (CITY) (STATE) (ZIP CODE)

Phone Number: _____ *Fax Number:* _____

My health information will be used for the following purpose(s): _____

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient ❑ Outpatient ❑ TCC ❑ IRU
❑ Discharge Summary ❑ Imaging Reports ❑ PT/OT/Speech/Audiology

Treatment Dates: _____

❑ History & Physical ❑ Laboratory Reports ❑ Operative Reports ❑ Emergency Department Record
❑ Consultations ❑ Transfer Abstract ❑ Transfer Abstract ❑ Pathology Reports
❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions
❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts
❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services
❑ Specific Exclusions: _____

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ will or ❑ will not receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires **[insert date or event]** if less than ninety days:_____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: **Ripepi Surgical Associates 2000 Oxford Drive, Suite 216 Bethel Park, PA 15102**

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Hospital, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient / Patient Representative Signature

Date: _____ **Time:** _____ AM / PM

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two (2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

_____ _____/_____/_____
Witness Date

_____ _____/_____/_____
Witness Date