HARMONY TRANSFORMATIONS ROOTS

Patient Registration Form

Patient Name: _____ SSN:_____

Patient DOB: _____ Sex: Male / Female / Non-Binary

Email Address:_____

Would you be interested in having communications sent to you via email? (Ex: Appointment reminders, Administrative updates, and health bulletins) Yes / No

Address:_____City:_____State:_____Zip:_____

Cell Phone Number:_____ Work Phone Number:_____

Primary Care Physician:_____ Phone Number:_____

How did you hear about us? _____

_____

Person responsible for Bill or Payment (Only complete this section if different from above patient)

Name: _____ SSN:_____

DOB: _____ Sex: Male / Female Phone Number:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone Number:_____ Work Phone Number:_____

Employer Name:_____

Employer Address_____

_____

Emergency Contact

Name: _____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone Number:_____ Work Phone Number:_____

Insurance Information

Primary Plan Name:_____ ID Number:_____

Group Number:_____ Date Effective:_____ Policy Holder's Name:_____

Policy Holder's SSN:_____ Policy Holder's DOB:_____

Claims Address:_____City:_____State:_____Zip:_____

Secondary Plan Name:_____ ID Number:_____

Group Number:_____ Date Effective:_____ Policy Holder's Name:_____

Policy Holder's SSN:_____ Policy Holder's DOB:_____

Claims Address:_____City:_____State:_____Zip:_____

Patient Printed Name:_____ **Date of Birth:**_____

I authorize the release of any medical information necessary to process this bill, to my insurance company, and request payment of benefits to Transformations TMS Centers, PLLC. I acknowledge that I am financially responsible for the payment whether or not covered by insurance. Additionally, I understand that there is a $50 No Show/ Late Cancellation fee for appointments cancelled within less than 24 hours.

Signature:_____ **Date:**_____

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) Authorize all physicians of Transformations TMS Centers, PLLC. and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reason for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options, as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature:_____ Date:_____

Insurance Waiver: I understand the medical insurance and payment policies as outlined in the agreement with which I have been provided. I also understand that some insurance plans do not allow patients to submit claims for payment of services rendered by providers such as Transformations TMS Centers, PLLC, who do not participate with said insurance plans, I understand that the list of accepted insurance plans may change at any point during my treatment and that I am solely responsible for payment of services rendered outside of insurance coverage in that instance. The list of accepted insurance plans can be provided upon request.

I understand that I am solely responsible for payment for all services rendered by Transformations TMS Centers, PLLC. I further understand that it is my responsibility to determine, prior to submitting any claim to my insurance company for payment for services rendered by Transformations TMS Centers, PLLC., whether such claims are permitted by my insurance plan. I release Transformations TMS Centers, PLLC. from any responsibility regarding my medical insurance and acknowledge that any attempt to obtain reimbursement from my insurance company is solely mine and is in no way endorsed by Transformations TMS Centers, PLLC.

Signature:_____ Date:_____

Receipt of Privacy Practices: I have received a copy of and have had an opportunity to ask questions about the privacy practices of Transformations TMS Centers, PLLC.
Signature:_____ Date:_____

Consent to Share Medical Records: Transformations TMS Centers, GR&W, INC. Roots and Harmony are sister companies and I understand that the mentioned companies may share my medical records so that I may receive the best medical treatment.

Signature:_____ **Date:**_____

TRANSFORMATIONS

Phone: 724-242-8671 Fax: 724-242-8672

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize ***Transformations*** to release/obtain general medical, as well as HIV test results, psychiatric, alcohol, drug abuse information from my health record in accordance with *Pennsylvania Law (55 PA3800.20), Federal Regulations(42CFR Part 2), and/or HIPAA (CFR 164.508)*. **"Release" may be (Check all that apply):**

( ) Copies of records ( ) Review of records ( ) Verbal exchange of information

To/From:(name/address/phone#)_____

_____

_____

Information is to be used for:_____

A general medical authorization and subpoena duces tecum without a specific authorization to release HIV test results/psychiatric/alcohol/drug abuse information must have this waiver from the client or his/her empowered representative.

The below listed information is ___ to be obtained and/or ___ to be forwarded as follows:

( ) Discharge Summary	( ) Psychiatric Evaluation	( ) History & Physical	( ) NPT Results
( ) Psychosocial	( ) Progress Notes	( ) Radiology reports	( ) Lab Results
( ) Medication History	( ) ECT Results	( ) Billing _____	( ) Other_____

I understand that I have the right to refuse to sign this authorization and that the facility named above is released from all legal liability that may arise from not releasing the information requested.

This consent is subject to revocation at any time except to the extent that the facility which is to make the disclosure has already taken action in reliance on it.
This authorization will expire one year from the date signed or on this given date: _____

I hereby release Transformations from liability which may arise as a result of the use of information disclosed by this authorization, should it be presumed that such information is later used to my detriment.

PATIENT NAME: _____ **D.O.B**: _____ **SS#:**_____

PATIENT DATE:_____ **SIGNATURE**: _____

EMPOWERED REPRESENTATIVE SIGNATURE: _____ **DATE:**_____
(If patient is unable to sign) Legal guardianship must be substantiated with legal documentation accompanying this authorization.

WITNESSSIGNATURE (REQUIRED): _____ **DATE**:_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) strictly prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of clinical or medical information if held by another party is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient. The confidentiality of HIV antibody test results is protected by Pennsylvania Law, which prohibits any further disclosure without specific written consent of the patient or as otherwise permitted by state law.
All requests for patient health information will be maintained in the patient's medical records indefinitely or until the record is destroyed in accordance with the record retention guidelines.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL