



New Patient Registration Form

Patient Demographics

Last Name: _____ First Name: _____

Middle Name _____ Preferred Name: _____

Date of Birth: _____ Social Security Number: _____

Sex: Male Female

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email Address: _____

Preferred Language: _____ Interpreter Needed: Yes No

Marital Status: Single Married Divorced Widowed Partnered

Employment Status: Full Time Part Time Unemployed Retired

Student Self Employed

Employer: _____ Occupation: _____

Preferred Pharmacy: _____

Preferred Lab: _____

Previous Health Care Providers: _____

Previous or Current Specialists: _____

Last Wellness Visit: _____

Current Medical Issues: (diabetes, high blood pressure etc)

Current Prescribed Medications: (Name and Dose)

Emergency Contact Information

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Primary Insurance

Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Policy/ID Number: _____ Group Number: _____

Insurance Phone Number: _____ Effective Date: _____

Secondary Insurance

Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Policy/ID Number: _____ Group Number: _____

Insurance Phone Number: _____ Effective Date: _____

Acknowledgment and Consent

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that this information will be used for medical care and billing purposes. I authorize the clinic to contact me using the information provided above.

Name of Patient/Guarantor (Please Print)

Relationship to Patient

Signature of Patient/Guarantor

Date



AI-Assisted Dictation Policy

Golden Heart Medical LLC utilizes AI-assisted dictation technology to support the accurate and efficient documentation of patient encounters. This technology is used to enhance clinical workflow, improve documentation quality, and allow providers to focus more on patient care during visits.

How It Works

During your visit, your provider will use AI-assisted dictation to transcribe spoken conversation into written clinical notes in real time & shortly after the encounter.

- The system converts speech into text for inclusion in your medical record
 - The provider reviews, edits, and finalizes all documentation for accuracy
 - AI tools assist with transcription only and do not make clinical decisions
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Security & Privacy Measures

We are committed to protecting your health information in accordance with the Health Insurance Portability and Accountability Act and all applicable privacy regulations.

- All AI-assisted documentation tools are selected with strict privacy and security standards
 - Any data processed is handled securely and in compliance with HIPAA requirements
 - Access to your medical information is limited to authorized personnel only
 - Providers review and verify all documentation before it becomes part of your official medical record
 - No information is shared outside of approved and secure systems
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Patient Acknowledgement & Consent

AI-assisted dictation is a required component of clinical documentation at Golden Heart Medical LLC. This technology is used solely to support your provider and improve the accuracy and efficiency of your medical record. Patients who decline the use of AI-assisted dictation acknowledge that care cannot be provided at this practice.

_____ Date _____

Patient/Guardian (Please Print)

_____ Date _____

Patient/Guardian Signature



Agreement of Financial Responsibility

- Payment is due at the time services are rendered. We accept cash, check, credit cards, and insurance plans with which we are contracted.
- For patients with in-network insurance, we will bill your insurance company after collecting any applicable copayment, coinsurance, or deductible at the time of service. Once your claim is processed, you will be billed for any remaining balance. Please allow approximately 45–60 days for claim processing.
- We make reasonable efforts to verify insurance coverage prior to your visit; however, this does not guarantee coverage or payment. It is your responsibility to provide accurate and current insurance information, including any changes. Failure to do so will result in full payment being due at the time of service.
- It is your responsibility to understand your insurance benefits, including whether we are in-network, what services are covered, any exclusions, and any prior authorization requirements.

• Prior Authorization & Appeal Service:

Processing prior authorizations and/or appeals is a time intensive administrative service not covered by insurance. As a courtesy, our clinic offers this service for a non-refundable processing fee. Standard prior authorizations and/or appeal requests: \$50 processing fee. Requests requiring phone communication to insurance companies: \$100/hour billed in 15 min increments. Payment does not guarantee approval and is patient responsibility.

• Out-of-Network / Self-Pay Patients:

Patients whose insurance we are not contracted with, or those who choose not to use their private insurance, are considered self-pay. Payment in full is required at the time of service. Payment plans are offered at the discretion of the clinic. A signed agreement and a \$50–\$100 down payment are required before a payment plan can be established. Upon request, we will provide a detailed receipt & visit notes that you may submit to your insurance company for possible reimbursement. Reimbursement is not guaranteed.

• A valid photo ID and current insurance card are required. We will retain copies for our records. Please note, providing your insurance card does not guarantee active coverage or payment for services by your insurance company.

I have read and understand the financial policies above. I agree to be responsible for all charges incurred. If my insurance denies coverage or payment for any services, I understand that I am responsible for the full balance.

_____ Date _____

Patient/Guardian (Please Print)

_____ Date _____

Patient/Guardian Signature



Consent to Release Healthcare Information

If applicable I _____ authorize Golden Heart Medical LLC to access my electronic health records from Foundation Health Partners facilities (including FMH, Emergency Department, Laboratory, and Imaging), as well as LabCorp, Quest Diagnostics, and North Star Radiology. I understand that I may revoke this authorization at any time in writing.

Patient Name

Date

Patient/Guardian signature

Authorization to Release Information to Family & Designated Individuals

Under HIPAA regulations, we cannot disclose your medical, diagnostic, or financial information without your written authorization. If you would like us to share this information with another individual (such as a spouse, partner, parent, child, or friend), you must complete and sign this form.

You may revoke this authorization at any time by providing written notice; however, this will not apply to any information already disclosed based on your prior authorization.

I authorize Golden Heart Medical LLC to disclose my medical, financial and related information to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Authorization for Communication (Please check all that apply)

____ I authorize Golden Heart Medical LLC to leave detailed messages on my home or mobile phone regarding appointments, medical care, test results, and billing information.

____ I authorize Golden Heart Medical LLC to send messages, including lab, imaging, diagnostic results, and billing information, via secure email to the email address on file.

____ I authorize Golden Heart Medical LLC to leave messages with any person who answers my phone.

OR

____ Messages may only be left with: _____

_____ Date _____

Patient Name (please print)

_____ Date _____

Patient/Guardian Signature



Appointment Attendance Policy

Golden Heart Medical LLC values your time and the time of our healthcare team. To ensure timely access to care for all patients, we maintain the following appointment policy:

Cancellation Requirements

- Appointments must be cancelled or rescheduled at least **24 hours in advance**
- Cancellations can be made by phone during business hours

No-Show and Late Cancellation Fee

- A **\$75.00 fee** will be charged for:
 - Missed appointments without prior notice
 - Cancellations/reschedules made less than 24 hours before the scheduled appointment time
- **Insurance does not cover no-show or late cancellation fees** and payment is the patient's responsibility.
- **Patients arriving more than 10 minutes late** to their scheduled appointment will be rescheduled and subject to a \$75 late fee.

Consequences of Repeated Missed Appointments

- **Three** no-shows or late cancellations/reschedules may result in:
 - **Discharge from the practice** (after written notification)

Exceptions

We understand that emergencies happen. Please contact us as soon as possible if you experience:

- Medical emergency requiring immediate care elsewhere
- Hospitalization

- Other extenuating circumstances

We will review exceptions on a case-by-case basis.

Patient Acknowledgment

I have read and understand the appointment attendance policy of Golden Heart Medical LLC. I agree to provide at least 24 hours' notice for appointment cancellations/reschedules and understand that failure to do so may result in a \$75.00 fee and/or dismissal from the clinic. I acknowledge that repeated violations of this policy will affect my ability to schedule future appointments.

_____ Date _____

Patient/Guarantor Name (print)

_____ Date _____

Patient/Guarantor Signature



Prescription Refill Policy

All prescription refill requests must be submitted directly to our office via phone call or email. Requests initiated by pharmacies may not be processed, as their automated systems may generate refill requests for medications you are no longer taking.

Please note: Medication refill requests may take up to 3 business days to process. Please plan ahead and contact our office before running out of your medication. Your provider may require you to schedule a visit before a refill will be processed.

In order to process your medication refill request, you must provide **all** the information listed below.

- Patients Full Name
- Date of Birth
- Contact number
- Medication **Name, dose & frequency**
- Preferred Pharmacy

Controlled Substances

All controlled substance refill requests require an appointment, as outlined in your signed Controlled Substance Agreement. No exceptions. Controlled substance prescriptions will be provided as a paper prescription only; electronic refills will not be issued.

Controlled substance prescriptions will not be sent to mail-order pharmacies, as we do not have tracking ability. They must be filled at a local pharmacy.



Acknowledgment, Authorization and Consent

- I have read and understand the HIPAA/Privacy Policy for Golden Heart Medical LLC

Initial _____

- I consent to evaluation, treatment, and medical services deemed necessary by my provider.

Initial _____

- I authorize my insurance company to pay benefits directly to Golden Heart Medical LLC and permit release of any information necessary to process claims.

Initial _____

- I understand that I am financially responsible for all charges not covered by my insurance.

Initial _____

- I understand that missed appointments or late cancellations/reschedules may result in a fee as outlined in the Financial Policy.

Initial _____

- I authorize Golden Heart Medical LLC to obtain/have access to my medication history.

Initial _____

- I understand that authorized communication methods (phone, email, text) may have some inherent privacy risks, and I accept these risks.

Initial _____

- I understand that prescription refills require 72 hour advance notice and may require an appointment.

Initial _____

- I understand my provider uses AI-assisted dictation to document and transcribe our visits into my medical record, as outlined in our AI-Assisted Dictation Policy.

Initial _____

_____ Date _____

Patient/Guardian (Please Print)

_____ Date _____

Patient/Guardian Signature