NEW PATIENT REGISTRATION:

G. MICHAEL PITTMAN, M.D.

3190 IRVINE RD
RICHMOND, KY 40475
PHONE: 859-369-0070 FAX: 859-369-0073

DATE_____ HOME PHONE_____ CELL PHONE_____

PERSONAL INFORMATION

NAME (LAST)_____ (FIRST)_____ (MI)_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

GENDER ◯M ◯F AGE_____ BIRTHDATE_____

SOCIAL SECURITY NUMBER_____

MARITAL STATUS ◯SINGLE ◯MARRIED ◯DIVORCED ◯WIDOWED ◯SEPARATED

EMPLOYER INFORMATION

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ WORK PHONE_____

HOW DID YOU HEAR ABOUT US?_____

EMERGENCY CONTACT INFORMATION

NAME_____ PHONE _____

INSURANCE/PHARMACY INFORMATION

PRIMARY INSURANCE_____ ID#_____ GROUP#_____

SECONDARY INSURANCE_____ ID#_____ GROUP#_____

PREFERRED PHARMACY_____ CITY_____ PHONE_____

ASSIGNMENT AND RELEASE

I, _____(THE UNDERSIGN) CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH_____ _____AND ASSIGN DIRECTLY TO DR. G. MICHAEL PITTMAN ALL INSURA NCE BENEFITS. IF ANY, OTHERWI SE PAYABLE TO ME FOR SERVICES RENDERED. I UNDE RSTAND THAT I AM FINANCI ALLY RESPONSIBLE FOR AL L CHARGES WHETHER OR NOT P AM BY INSU RANCE. I HEREBY AUTHORIZE THE OCCASIONAL RELEASE OF A LL INFORMATION NECESSARY TO SE CURE THE PAYMENT OF BENEFITS. I AUTHORIZE THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGE

I ACKNOWLEDGE THAT GEORGE M. PITTMAN, M.D., PLLC HAS PROVIDED ME A COPY OF IT'S PRIVACY PRACTICES, WHICH PROVIDES A DESCRIPTION OF THE USES AND DISCLOSURE ALLOWED, AS WELL AS OTHER RIGHTS I HAVE REGARDING MY PROTECTED HEALTH INFORMATION.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____ _____
SIGNATURE OF WITNESS DATE

CONSENT TO RELEASE INFORMATION

WE MAY D ISCLOSE YOUR PROTECTED HEALTH INFORMATION TO A MEMBER OF YO UR FAMILY, A RELATIVE, A CLOSE FRIEND, OR ANY PERSON YOU IDENTIFY WHO MAY BE INVOLVED IN YOUR HEALTH CARE WE MAY USE OR DISCLOSE SUCH IN FORMATION NECESSARY IF WE DETERMINE THAT IS IT IN YOUR BEST INTEREST BASED ON OUR PROFESSIONAL JUDGEMENT. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATIVE, OR ANY OT HER PERSON THAT IS RESPONSI BLE FOR YOUR CARE OR GENERAL CONDITION. YOU MAY REVOKE T HIS CONSENT AT ANY TIME BY SUBMITTING A WRITTEN REQUEST TO OUR OFFICE.

WE WILL ONLY RELEASE INFORMATION TO AN INDIVIDUAL IF THEIR NAME IS LISTED BELOW

NAME	PHONE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONSENT TO PROVIDE TREATMENT TO CHILD WITHOUT PARENT PRESENT
(THOSE ALLOWED TO BRING YOUR CHILD TO HAVE TREATMENT PESIDES YOU)

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

SIGNATURE_____ DATE_____

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RICHMOND, KY 40475
PHONE: 859-369-0070 FAX: 859-369-0073

AUTHORIZATION TO USE/DISCLOSE MEDICAL INFORMATION

I, _____, AUTHORIZE AND/OR REQUEST THE FAMILY CLINIC TO USE OR DISCLOSK THE FOLLOWING INFORMATION CONTAINED IN MY MEDICAL RECORDS TO

_____
(IDENTITY OF PERSON(S) OR CLASS OF PERSONS TO WHOM DR. PITTMAN MAY DISCLOSE INFORMATION, ADDRESS, ETC IF APPLICABLE (IE OTHER DRS, FAMILY MEMBERS, ETC)

PATIENT NAME_____ SOCIAL SECURITY #_____

DATE OF BIRTH_____

INFORMATION REQUESTED: TIME PERIOD FROM _____ TO _____

☐ ENTIRE MEDICAL RECORD
☐ RADIOLOGY REPORT
☐ DISCHARGE SUMMARY
☐ OPERATIVE REPORTS
☐ PATHOLOGY REPORT
☐ EMERGENCY ROOM RECORD
☐ FACE SHEET
☐ LABORATORY RESULTS
☐HISTORY & PHYSICAL
☐ OTHER CONFINED TO THE FOLLOWING SPECIFIC INFORMATION_____

I UNDERSTAND THAT THIS RELEASE MAY INCLUDE MEDICAL RECORDS OF TREATMENT FOR PHYSICAL AND OR EMOTIONAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR DRUG ABUSE, PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENT(S), OR SEXUALLY TRANSMITTED DISEASE I ALSO UNDERSTAND THAT HIV, AIDS, OR AIDS RELATED INFORMATION MAY BE RELEASED. I UNDERSTAND THAT IF THE PERSON OR ENTITY THAT VIFWS THAT INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL AND STATE PRIVACY REGULATIONS, THE INFORMATION DISCLOSED MAY BE RE-DISCLOSED AND NO LONGER PROTECTED BY FEDERAL AND STATE PRIVACY REGULATIONS. I UNDERSTAND THAT UNLESS I REVOKE IT SOONER, THIS AUTHORIZATION WILL EXPIRE ON THE DATE, EVENT, OR CONTITION _____. IF I FAIL TO SPECIFY AN EXPERATION DATE, EVENT, OR CONDITION, THIS AUTHORIZATION WILL EXPIRE EN- SIX MONTHS FROM THE DATE IT IS SIGNED. EXCE PT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION, I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME BY

1.) RETURNING A COPY OF THIS AUTHORIZATION FORM WITH REVOCATION INTENTIONS CLEARLY STATED OR
2.) SENDING A LETTER OF REVOCATION OF THIS AUTHORIZATION TO:
GEORGE M. PITTMAN, MD
3190 IRVINE RD
RICHMOND, KY 40475

SIGNATURE_____ DATE_____

If the signature above is from a legal personal representative, provide a description of the personal representative's authority to act on behalf of the individual:_____

WITNESS_____

☐ MAIL TO ABOVE ADDRESS ☐ FAX TO ABOVE NUMBER ☐ DATE NEEDED_____