REGISTRATION FORM

PATIENT INFORMATION

Date:

Facility:

Legal Last Name:

Legal First Name:

Date of Birth:

Chosen first name (if different):

Social Security Number/Medicare Beneficiary Identifier:

Parent/Guardian Name (If patient under 18 years old):

Preferred Pronoun:
☐ He ☐ She ☐ No Pronoun

Billing Address:

Apt #:

Zip:

City:

State:

Sex Assigned at Birth:
☐ Male
☐ Female
☐ Intersex
☐ Decline to Answer

Preferred Phone number:

OK to Text/Voicemail ☐ Yes ☐ No

Alternative Phone number:

OK to Text/Voicemail ☐ Yes ☐ No

E-Mail Address: *Must be 18 years of age or older*

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Decline

Primary Language: ☐ English ☐ Spanish ☐ Somali ☐ Russian ☐ Other:

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Decline

Ethnicity: ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino ☐ Decline

Primary Care Provider Name:

Primary Care Clinic:

Clinic Phone Number:

EMERGENCY INFORMATION

Name:

Relationship:

Phone #:

INSURANCE INFORMATION

Do you have current insurance: ☐ Yes ☐ No

Insurance Carrier:

Policy #

Group#

Name of Insured (if different):

Relationship:

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PATIENT CONSENT FORM

This consent applies to all providers and locations where I/my child receive care.

1. Consent for treatment

I understand that I/my child have a condition that requires diagnosis and treatment. I will have a chance to discuss with my/my child's Care Team the treatment that the Care Team believes is needed. To provide this, Care Teams may collect information about my/my child's health, including Medical History and/or family history. Care Teams will answer my questions about treatment, and I may refuse any recommended treatment. Care Teams cannot promise specific results. Please check to agree or disagree to the terms.

☐ Agree ☐ Disagree

If Disagree, Please Consult Your Care Team

2. Prior Authorization & Assignment of Insurance Benefits

The rules of my/my child's insurance plan may require approval before I/my child have certain treatments or services. If I don't get approval, the plan may not pay for the treatments or services.

Livio Health Group may bill my insurance and I ask that my/my child's insurance payments be made to Livio Health Group. Care Teams may share my/my child's health and account records with payers and their agents as needed for billing, payment, claims, quality, improvement, care coordination, and other health plan activities as permitted by law. This includes investigations or quality reviews. I will pay for all services not covered or paid by a third party (such as an insurance company). If I need help paying for my care, I will ask about my options when I register.

☐ Agree ☐ Disagree

3. Release of Information

Care Teams may release my/my child's health records to other providers, community health workers and agencies or health plans for use in my treatment, including care coordination. Care Teams may also share my/my child's health records with quality or other organizations for health care operations as described in the Notice of Privacy Practices. My/my child's records will be stored for as long as policy requires. The Care Team may share my medical information with the facility where I/my child am receiving care. *Refer to HIPAA Authorization Section 3*

☐ Agree ☐ Disagree

4. Consent to Download Your Medication History

This consent provides Livio Health Group with my permission to download, review, and use my e-Medication history for evaluation and continuation of care needs. By checking the box below, I am indicating that I consent to Livio Health Group accessing and using my/my child's e-Medication history as is appropriate for my/my child's care.

☐ Agree ☐ Disagree

If Disagree, Please Consult Your Care Team

5. Communication

I understand that the Care Team may need to contact me about my/my child's care and account. I give Livio Health Group or their approved agents permission to contact me by phone (including my cell phone), US mail, email, or via the patient portal.

☐ Agree ☐ Disagree

6. Important Information to Patients

I have received the Notice of Privacy Practices and Patient Bill of Rights _____ (Initials).

I understand I may have access to my child's general medical record but not to any confidential services provided as stated in the Minnesota Statute 144.341-347.

_____ (Initials).

_____

PATIENT PRINTED NAME (Or Legal Representative)

_____

SIGNATURE OF PATIENT (Or Legal Representative)

_____

RELATIONSHIP TO PATIENT

DATE (MM/DD/YYY): _____

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization:**
   I hereby authorize Livio Health Group to use and/or disclose the protected health information described below to healthcare providers, insurance companies, and partners that are involved in my/my child's care.

2. **Effective Period of Authorization:**

This authorization for release of information covers the period of healthcare from:	☐ All Past, Present, and Future Periods **OR** ☐ _____ (MM/DD/YYYY) TO _____ (MM/DD/YYYY)

3. **Extent of Authorization:**

☐ I authorize the release of my/my child's COMPLETE health record except for services under MN Statute 144.341-347 This includes records relating to mental healthcare*, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.	***OR***	☐ I authorize the release of my/my child's COMPLETE health record with the EXCEPTION of the following information: **Please check all that apply* ☐ Mental Health Records* ☐ Communicable Disease (includes HIV and AIDs) ☐ Alcohol/Drug Abuse Treatment ☐ Other (please specify): _____

**Federal law prohibits the release of psychotherapy notes unless a separate authorization form is completed for the release of such notes.*

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization will remain in effect until terminated by me in writing, at which time this authorization will expire.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my/my child's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may not be subject to privacy laws and such person may be able to release the information and may no longer be protected by federal or state law.

_____ Signature of Patient or Legal Representative

_____ Relationship to Patient (if Legal Representative)

_____ Printed Name of Patient or Legal Representative

_____ Today's Date (MM/DD/YYYY)

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Name: _____ Date of Birth: _____

GENERAL HISTORY

Problems:

☐ Hypertension ☐ Diabetes ☐ Depression ☐ Anxiety

☐ PTSD ☐ Bipolar ☐ Arthritis ☐ ADHD

☐ Asthma ☐ COPD ☐ Hepatitis C Other:

Allergies (Medications/Food/Enviromentals): ☐ Yes ☐ No

If yes, what allergies?

Tobacco Use:

☐ No

☐ I used to: Year Quit: _____

☐ Yes: Type: _____

Daily Use and # Years? _____

Alcohol Use:

☐ No

☐ I used to: Year Quit:_____

☐ Yes, _____ounces per day/ month/year (circle one)

Drug Use:

☐ Never

☐ In the past

☐ Current:

Drug(s) of Choice:_____

IV Use:

☐ Current

☐ In the past

☐ Never

Surgeries:

Family History of Illness:

Gender Identity: ☐ Male ☐ Female ☐ Genderqueer/Nonconfirming

☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male) ☐ Decline to answer

Sexual Orientation: ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Straight ☐ Something Else ☐ Decline

A Livio Community Health Worker will contact you to get you connected to the following resources:

Do you need help accessing any of the following?

- Transportation ☐ yes ☐ no
- Food resources ☐ yes ☐ no
- Utility help ☐ yes ☐ no
- Employment Services ☐ yes ☐ no
- Help Establishing primary care ☐ yes ☐ no