Patient Registration Information

Name _____ **Date of Birth** _____
Last First MI

Address _____
Street City State Zip Code

Home Phone _____ **Cell Phone** _____ **Social Security#**_____

Sex: Male / Female **Race:**_____ **Hispanic: Y/N** **Preferred Language:**_____

Marital Status: S/M/D/W **Email address:** _____ **May we contact you via email: Y/N**

Employer _____ **Work Phone** _____

Is this a work related injury? ( ) Yes ( ) No If yes, please give claim # _____

Who should we contact in case of emergency? _____ _____
Name and Phone Number Relationship to Patient

Insurance Information-Please give your card to the receptionist for copying.

Primary Insurance _____

Policyholder's Name _____ Date of Birth _____

ID Number _____ Group Number _____

Secondary Insurance _____

Policyholder's Name _____ Date of Birth _____

ID Number _____ Group Number _____

Pharmacy Information

Preferred Pharmacy Name_____ Preferred Pharmacy Phone Number_____

Parent/Guardian or Person Responsible for Paying Bill

Name: _____ DOB _____ Relationship to Patient _____
Last First MI

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ SS# _____

To the best of my knowledge the above information is complete and correct. I understand it is my responsibility to inform PCG and its staff if I or my child/ward has a change in health, insurance coverage or contact information.

_____ _____
Signature of Patient, Parent or Guardian Date

How did you hear about us?

( ) I was a former patient ( ) I am a Hospital Associate ( ) From a Hospital Associate

( ) Employer Recommendation ( ) Web Page ( ) I saw you on TV

( ) Doctor Recommendation _____

( ) Insurance Co Recommendation _____

( ) Family/Friend Recommendation _____

( ) Former Patient Recommendation _____

( ) I learned about you another way. Please explain _____

CONSENT FOR CARE
I hereby give my consent for treatment at **Primary Care Group.**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I hereby authorize payment to **Primary Care Group** for services rendered to me or my dependants.
I also authorize this office to release any information necessary to expedite insurance claims.

LIFETIME AUTHORIZATION TO FILE MEDICARE
I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Primary Care Group** for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed October 2002.

COLLECTIONS AGREEMENT
By signing below, I agree to pay the fee of 12.5% of outstanding charges should my account be turned over to an outside collection agency. By not signing, I agree to pay in full for services at the time they are rendered. **Primary Care Group** will bill my insurance carrier, however I understand and agree that I am responsible for payment of all charges for services provided, regardless of any insurance coverage(s).

RETURNED CHECK FEE
By signing below, I agree to pay the returned check fee of $25 should my bank refuse to honor my check. By not signing, I understand I may not be allowed to write checks for services rendered at this location.

Signature _____ _____ Date _____
Patient, Parent or Guardian Relationship to Patient

Please place a check mark in EACH BOX indicating your consent:

YES ☐ NO ☐ **AUTHORIZATION TO LEAVE MESSAGE**
I hereby authorize **Primary Care Group** to leave a message regarding appointments or tests at my residence or cell phone.

YES ☐ NO ☐ **AUTHORIZATION TO SEND APPT REMINDERS VIA TEXT MESSAGE or AUTOMATED VOICE MESSAGE**
I hereby authorize **Primary Care Group** to send appointment reminders to me via text message or automated voice message system. It is my responsibility to provide the clinic with the most up to date contact information.

YES ☐ NO ☐ **PHOTO CONSENT**
I hereby authorize **Primary Care Group** to take my picture for my electronic medical record.

YES ☐ NO ☐ **RX CONSENT**
I hereby authorize **Primary Care Group** to electronically access my prescription history through RX Hub (a prescription database compiling all prescription history).

Signature _____ _____ Date _____
Patient, Parent or Guardian Relationship to Patient

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record. This can include any family member or other healthcare provider.

Name	Relationship to Patient	Phone Number

By signing below, I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature _____ _____ Date _____
Patient, Parent or Guardian Relationship to Patient

ACKNOWLEDGMENT

Patient Name: _____

Patient Acknowledgment: I acknowledge that a copy of the Notice of Privacy Practices for Methodist Le Bonheur Healthcare has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand the most current version of the Notice will be posted within the Health System and on www.methodisthealth.org/ patients-guests/patient-privacy-practices.dot.

Signature of Patient: _____ Date: _____

Signature of Patient's Authorized Representative, Signing on Behalf of Patient:_____

Basis of Authority to Sign for Patient:_____

For Use by Health System Personnel Only: [Complete if patient Acknowledgment is not obtained]

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____.

Signature of Health System Representative: _____
Date: _____