Methodist Healthcare

PATIENT REGISTRATION INFORMATION
PHYSICIAN PRACTICES

Who Is your Primary Care Provider? _____

Patient Account Number _____

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

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell:** _____ **SSN:** _____

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

Marital Status: _____ **E-mail** _____ **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

Pharmacy Name _____ **Pharmacy Phone** _____

Parent/Guardian or Person Responsible for Paying Bill

Name: _____ **DOB** _____ **Relation to Patient:** _____
First MI Last

Address: _____
Street City State Zip Code

Home Phone: _____ **Cell:** _____ **SSN:** _____

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

Signature _____ _____
Patient, Parent or Guardian Date

How did you hear about us?

( ) I was a former patient
( ) Employer Recommendation
( ) Doctor Recommendation
( ) Insurance Co Recommendation
( ) I learned about you another way. Please explain. _____
( ) I am a Hospital Associate
( ) Web Page
( ) From a Hospital Associate
( ) I saw you on TV

Advance Directive:

Do you have an Advance Directive, also known as a living will? Yes ____ No _____ (If No, would you like information on an Advance Directive?)

Consent For Care:
I hereby give my consent to examination or treatment by the clinic's medical staff, including diagnostic services, medications, laboratory procedures, behavioral health or other medically necessary services.

Authorization To Pay Insurance / Third Party Benefits To Physician or Clinic and Release Information to File Insurance:
I authorize direct payment to the Clinic and other medical providers the health insurance benefits that I am entitled to or are otherwise due or payable to me. I also authorize this office to release any information necessary to assist in getting the insurance claims filed appropriately. Also, where appropriate, I request that payment of authorized Medicare, TennCare or Medicaid benefits for services provided to me, be made directly to the Clinic or other medical providers. I also authorize any holder of medical information about me to release that information to the Center for Medicare/Medicaid Services and its agents if needed to determine the benefits payable for related services

Financial Agreement:
I understand that I am responsible for payment of the charges incurred for services provided to me. If I have given health insurance information, the clinic or medical provider will file the claim for the medical and/or behavioral health services provided. If I do not have health insurance or there is a balance after insurance, I may be responsible for the amount of the bill.

Rx Consent:
I hereby authorize the release of medical information required to share and /or receive prescription information for my treatment medication including access of my prescription history.

Acknowledgement of Receipt of Privacy Notice:
I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, and may request another copy if needed, by asking the front desk.

The undersigned patient or representative agrees that Methodist Healthcare, its affiliates and agents, may use an automated telephone dialing system, pre-recorded messages and/or texting, to contact the cellular telephone number(s) that have been provided for appointment, payment and collection purposes. It is my responsibility to provide the clinic with the most up to date information.

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

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

YES	NO	
		AUTHORIZATION TO LEAVE MESSAGE
( )	( )	I hereby authorize **Methodist Healthcare** to leave a message regarding appointments or tests at my residence or cell phone.
		AUTHORIZATION TO SEND APPT REMINDERS OR OTHER ALERTS VIA TEXT MESSAGE or AUTOMATED VOICE MESSAGE
( )	( )	I hereby authorize Methodist Healthcare 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.
		PHOTO CONSENT
( )	( )	I hereby authorize Methodist Healthcare to take my picture for my electronic medical record
		RX CONSENT
( )	( )	I hereby authorize Methodist Healthcare to electronically access my prescription history through RX Hub (a prescription database compiling all prescription history).

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

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

Name _____ Relationship to Patient _____ Phone Number _____

Name _____ Relationship to Patient _____ Phone Number _____

By signing below, I understand I may revoke the authorizations in this document 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 _____ _____ _____
Patient, Parent or Guardian | Relationship to Patient | Date

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