

PARKVIEW MEDICAL GROUP PATIENT REGISTRATION FORM

PATIENT					
NAME First Middle Last			DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER-MEDICAL CONDITION <input type="checkbox"/> OTHER-UNKNOWN	
STREET ADDRESS			MAILING ADDRESS (PO BOX)	TELEPHONE – HOME	
CITY			STATE	ZIP CODE	TELEPHONE – WORK
EMPLOYER			LENGTH OF EMPLOY	EMPLOYMENT STATUS Full Time Part Time Self-Employed Unemployed Retired Active Duty	
SOCIAL SECURITY NUMBER	PRIMARY LANGUAGE		STUDENT STATUS Full Time Part Time Not Student		MARITAL STATUS Single Separated Married Divorced Widowed

RESPONSIBLE PARTY				
NAME First Middle Last			DATE OF BIRTH	SEX MALE FEMALE
ADDRESS			TELEPHONE – HOME	TELEPHONE - WORK
RELATIONSHIP TO PATIENT Parent Guardian Other	SOCIAL SECURITY NUMBER		EMPLOYER	

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
INSURANCE CARRIER NAME	INSURANCE CARRIER NAME
INSURANCE ID# GROUP # COPAYMENT	INSURANCE ID # GROUP # COPAYMENT
SUBSCRIBER (POLICY HOLDER) NAME: _____ ADDRESS: _____ PHONE # SS# BIRTHDATE:	SUBSCRIBER (POLICY HOLDER) NAME: _____ ADDRESS: _____ PHONE # SS# BIRTHDATE:
PATIENT-SUBSCRIBER RELATIONSHIP Self Spouse Dependent Other	PATIENT-SUBSCRIBER RELATIONSHIP Self Spouse Dependent Other

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?			
NAME	DAYTIME TELEPHONE	EVENING TELEPHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE

ALL PAYMENTS ARE DUE AT TIME OF SERVICE.

Assignment of Benefits/Financial Agreement. I understand that the HIPAA law grants Provider authorization to use and disclose my medical records for treatment/care and payment operations. I hereby authorize payment of health insurance benefits directly to PMG, not to exceed the balance due of the providers' customary charges for the services rendered. I understand that I will be responsible for all fees and charges deemed as my responsibility according to PMG and my health plan. I understand that if I do not provide a VALID insurance card before services are provided, I will be held financially responsible for all services. I further agree that I will pay any outstanding amounts in accordance with PMG's rates and terms. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate. I also understand that it is my responsibility to determine which laboratory participates with my insurance plan. Errors in this determination may result in denial of payment by the insurance company, in which case the financial responsibility will be my own.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM THE PATIENT OR DULY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT. I AGREE TO THE TERMS STATED ABOVE.

Patient's Signature: _____
or
Signature of Patient's Representative _____

Date: _____
Relationship to
Patient: _____

**FREDERICK MEMORIAL HOSPITAL AFFILIATE
PARKVIEW MEDICAL GROUP**

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Frederick Memorial Hospital Affiliate, Parkview Medical Group, (herein known as Provider"), have been given a copy of the Privacy Policy. I understand my rights according to this policy. I understand that the HIPAA law grants Provider authorization to use and disclose my medical records for treatment/care and payment operations.

Signature of Patient or Authorized Representative Date Witness

Privacy Policy refused by patient/guardian. Reason: _____

Communication Authorization

1. Provider may contact me at my home/work phone numbers, or my home address regarding my diagnosis, results, treatment and care, or payment. I may request any other means of communication (such as e-mail, cell phone, or mail to different address) or I may deny a particular means of communication in writing (below).

Yes, you may e-mail me at _____. I understand e-mail is NOT considered a private/secure method of communication

Yes, you may call my cell phone at _____. I understand cell phones are NOT considered a private/secure method of communication..

No, please do not contact me by the following means: _____

2. I understand that I may authorize Provider to share medical/billing information about my care to relatives, caretakers, close friends, etc., and shall list them below:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Communication authorization shall be expire under any circumstance as listed below:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient or legally responsible person.
3. In the case of a minor having reached the age of majority.

Print Patient's Name

Home Phone Number

Patient or Legally Responsible Person's Signature

Witness Signature Date

Office Use Only Entered by: _____ Date: _____
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