

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 <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty		
SOCIAL SECURITY #	PRIMARY LANGUAGE		STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Student		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Hispanic	<input type="checkbox"/> Multiracial <input type="checkbox"/> Refuse <input type="checkbox"/> White/Caucasian		ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused or Undetermined		

RESPONSIBLE PARTY			
NAME (First, Middle, Last)		DATE OF BIRTH	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
ADDRESS		TELEPHONE - HOME	TELEPHONE - WORK
RELATIONSHIP TO PATIENT <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	PATIENT-SUBSCRIBER RELATIONSHIP <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 agency for collection, I will pay reasonable 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 laboratories 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

Assignment of Benefits/Financial Agreement

I certify that the registration information I provided is true and accurate. I authorize payment of health insurance benefits directly to PMG, not to exceed balance due of PMG's customary charges for services rendered. I understand the following: Payment is due upon receipt of services. I am responsible for all fees & charges deemed my responsibility according to PMG & my health plan. If I do not provide a VALID insurance card before services are rendered, I will be held financially responsible for all services. I agree that I will pay any outstanding amounts in accordance with PMG's rates and terms. Should the account be referred to an agency for collection, I will pay reasonable fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate. It is my responsibility to determine which outside facilities participate with my insurance plan & which services require authorization and errors therein will result in denial of payment by insurance and my responsibility of fees. It is PMG's policy that prescription refill requests are processed only with proper follow-up visits and during business hours. I am the patient or person authorized to act on behalf of patient and agreed to terms herein.

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

Date: _____
Relationship to
Patient: _____

Acknowledgement of Receipt of Privacy Notice

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

Privacy Policy refused by patient/guardian
Reason: _____

Signature of Patient or Authorized Representative

Date

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 authorize my provider to share medical/billing information about my care/account to the following:

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

Date

Witness

Date

Office Use Only

Entered by: _____ Date: _____