Sacred Heart Medical Group

Registration Information

Thank you for coming to see us. You can speed your care by providing the following necessary information. When finished, please give this to the receptionist. This information will then go into our computer for future visits. Thank you.

Please **PRINT** and fill out this form **COMPLETELY**. Date: ________________________

PATIENT:

________________________ ________ ________________________
First Name Middle Initial Last Name

____
Previous / Maiden Name(s)

________________________ ____________ ________ ________
Street Address City State Zip Code

Phone: ( ) ________ - ______________ Birth Date: _______ / _______ / _______ SS#: _______ - _______ - _______

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Indian ☐ White ☐ Unknown ☐ Other: ______________

Are you seeking a family physician? ☐ Y ☐ N If not, who is your family physician?: ______________________

Employer: ______________________________ Work Phone: ( ) ________ - ______________

________________________ ____________ ________ ________
Street Address City State Zip Code

RESPONSIBLE PARTY: If other than patient.

________________ ________ ________________ ________________
First Name Middle Initial Last Name Relationship to patient

________________________ ____________ ________ ________
Street Address City State Zip Code

Birth Date: _______ / _______ / _______ SS#: _______ - _______ - _______ Home Phone: ( ) ________ - ______________

Employer: ______________________________ Work Phone: ( ) ________ - ______________

IN CASE OF EMERGENCY CONTACT:

Name: ______________________________________ Relationship ______________________

Home Phone: ( ) _______ - ______________ Work Phone: ( ) _______ - ______________

INSURANCE: Provide the following information if we will be filing your insurance. Any applicable copayments and/or deductibles will be required at the time of service. Please have cards available for copying. Failure to present valid/verifiable/updated proof of insurance may result in the patient being responsible for payment in full for services provided.

PRIMARY INSURANCE:

Insurance Company: ______________________________________ Policy #: ____________________

Subscriber Name: ______________________________ DOB: ____________ Group #: ____________________

SECONDARY INSURANCE:

Insurance Company: ______________________________________ Policy #: ____________________

Subscriber Name: ______________________________ DOB: ____________ Group #: ____________________

ASSOCOATE USE ONLY Registration / Insurance Verfied... Initial Top / Date Bottom

(A) RELEASE OF INFORMATION

I acknowledge that records concerning the patient are the property of Sacred Heart Medical Group and are maintained for the use and benefit of Sacred Heart Medical Group and its staff in providing care and treatment to the patient. I hereby authorize Sacred Heart Medical Group to disclose all or any part of my patient record to my admitting physician, consulting physician(s), hospital based physicians. I further authorize Sacred Heart Medical Group and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to the Medical Group or to me or a family member of mine, for all or part of the Medical Group's charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

(B) ASSIGNMENT OF BENEFITS

I assign payment of all insurance benefits, basic and major medical for this period of medical treatment to be made directly to Sacred Heart Medical Group.

(C) FINANCIAL AGREEMENT

For and in consideration of services rendered, each of the undersigned agrees to pay Sacred Heart Medical Group for all charges not covered by insurance payments as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by the Sacred Heart Medical Group including reasonable attorney's fees which shall include, but not be limited to, such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statues 222.11, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of a family which are greater than $500 per week garnished.

(D) STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Sacred Heart Medical Group. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

(E) STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Sacred Heart Medical Group for any services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

(F) AUTHORIZATION FOR MEDICAL CARE AND TREATMENT

1. I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures by Sacred Heart Medical Group and its medical and professional staffs, associates and agents and as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis or therapy as he considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Sacred Heart Medical Group.

(G) ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES

The Sacred Heart Health System Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted in all Sacred Heart Health System facilities. By signing this form, I acknowledge that I have been offered and/or received the Sacred Heart Health System Notice of Health Information Practices.

(H) The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

(I) Termination of care may result from failure to cooperate and/or compliance with Sacred Heart Medical Group Policy and Procedure.

Signature of Patient or Authorized Representative Date	Witness - 2 Date 2 required if minor seeks medical treatment with consent of parent or legal guardian.
Witness - 1 Date	