Patient Registration Information – Primary Care Group

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 Phone:** _____ **SSN:** _____

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

Marital Status: _____ **May we contact you via email:** **Y/N**

Email address: _____

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:** _____

Employer: _____ **Work Phone:** _____

Pharmacy Information

Pharmacy Name _____ **Pharmacy Phone** _____

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:** _____ **SSN:** _____

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 _____ _____
Patient, Parent or Guardian Date

Siblings

Name: _____ **DOB:** _____ **Brother/Sister**

Name: _____ **DOB:** _____ **Brother/Sister**

Name: _____ **DOB:** _____ **Brother/Sister**

Name: _____ **DOB:** _____ **Brother/Sister**

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 dependents.
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 September 23, 2013.

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 _____ _____ _____
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 **Primary Care Group** 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 **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.

PHOTO CONSENT

☐ ☐ I hereby authorize **Primary Care Group** to take my picture for my electronic medical record

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