St. Elizabeth PHYSICIANS

PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security # ____-____-_____ Last Name _____ First Name _____ Middle ____

Address_____ City _____ St ____ Zip _____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)____-_____

Emergency Contact _____ Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

Pharmacy most used by patient _____Pharm. Phone (____) ____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security # ____-____-_____ Name _____

Address _____ City _____ St ____ Zip_____

Home Phone (____)____-_____ Work Phone (___)____-_____ Ext. _____ Email: _____

Date of Birth _____ Marital Status _____ Race _____ Sex ___ Alternate Phone (____)_____-_____

Employer _____ Emp. Address _____ Emp. Phone (___)____-_____

PRIMARY INSURANCE COMPANY NAME_____ **No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ PrimaryCarePhysician_____ Copay _____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____ Date of birth _____ SS# ____-___-_____

Employer _____ Copay _____

I understand that I am responsible for payment for all services rendered. I hereby assign, and authorize direct payment of my medical benefits to St. Elizabeth Physicians. However, I understand and agree to pay all charges or amounts not timely paid by my insurance policy or plan including, but not limited to, any co-pays or deductibles. I acknowledge that it is my responsibility to know and understand the terms of my insurance policy or plan. I authorize St. Elizabeth Physicians to release all of my medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits, to authorize medical services to be received, to process claims for benefits, to represent me in a third-party payer's hearing or appeal process, and/or to collect any payments. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. In accordance with recognized coding standards, I understand that I may receive separate charges for procedures, physicals and/or other problem-oriented treatment during a single visit.

I further authorize the access and release of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers involved in my care.

I give my consent to St. Elizabeth Physicians to provide medical care and treatment to me as deemed necessary and proper by my physician. I authorize St. Elizabeth Physicians billing or my provider's office to contact me by my cell phone. _____YES _____NO

Signature X_____ Date _____
(Signature of patient or patient representative)

Witness _____