St. Elizabeth PHYSICIANS

Patient Registration / Consent to Treat / Notice of Privacy Practices

Please print the information below and have your insurance card and driver's license or legal photo ID available.

PATIENT INFORMATION

Last Name_____First Name_____Middle_____

Preferred Name_____

Address_____City_____St_____Zip_____

Mobile Phone (____)____-_____ Home Phone (____) ____-_____ Email:_____

Interpreter Needed: Y N Preferred Language: _____

May we leave detailed messages that would include protected health information (for example, test results, prescription refill information, appointment scheduling and cancellation, and billing information) on your voicemail? Y N

Social Security #_____-_____-_____Date of Birth_____Legal Sex_____

Race (check one):

_____ *American Indian/Alaska Native*
_____ *Asian*
_____ *Black or African American*
_____ *Native or Pacific Islander*
_____ *White or Caucasian*
_____ *Unknown*
_____ *Other*
_____ *Decline to Answer*

Ethnicity

_____ *Hispanic*
_____ *Non-Hispanic*
_____ *Decline to Answer*

Preferred Pronoun

_____ *She/Her*
_____ *He/Him*
_____ *They/Them*
_____ *Other*
_____ *Decline to Answer*

Marital Status

_____ *Single*
_____ *Married*
_____ *Widowed*
_____ *Divorced*
_____ *Separated*
_____ *Significant Other*
_____ *Other*
_____ *Decline to Answer*

Gender Identity:

____ *Male*
____ *Female*
____ *Transgender*
____ *Gender queer/ neither male or female*
____ *Decline to Answer*

Emergency Contact_____Phone (____)_____-_____
(Name) (Relationship)

Does the Patient have a Healthcare Power of Attorney, Advanced Directive, or Guardianship Order? Y N

Has St. Elizabeth Physicians received a copy? Y N

Pharmacy Most Used by Patient_____Pharm. Phone (____)____-_____

Referring Provider (Specialist office only) _____

Patient Employer_____Emp. Address_____Emp. Phone (____)_____-_____

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

Relationship to Patient: Self Parent Spouse Other _____

Social Security #_____-_____-_____Name_____

Address_____City_____St_____Zip_____

Primary Phone (____)_____-_____Alternate Phone (____)_____-_____Email:_____

Date of Birth_____Legal Sex _____ Employer_____

INSURANCE INFORMATION *(Provide card at front desk)*

PRIMARY INSURANCE COMPANY NAME _____No Insurance
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name:_____Date of Birth_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the St. Elizabeth Physicians Notice of Privacy Practices. The effective date of the Notice of Privacy Practices is September 23, 2013.

CONSENT TO TREAT

I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examination, administration of medications and vaccinations, recordings, and photographs for diagnosis and/or treatment, diagnostic tests, laboratory tests, and other minor procedures) to be performed by my physician, advanced practice provider, and any other associates of St. Elizabeth Physicians. I understand that I am responsible for payment for all services rendered. I authorize St. Elizabeth Physicians to act as my agent in helping me obtain payment from my insurance companies. I authorize payment to be made directly to St. Elizabeth Physicians. I authorize release of information to all my insurance companies which may be necessary to collect any payments. I further authorize access by St. Elizabeth Physicians of my medical information for treatment by St. Elizabeth Physicians and release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in 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 pre-certifications or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicians, and other problems during a single visit. I understand that St. Elizabeth Physicians will use your protected health information, as necessary, for your treatment, to obtain payment for treatment, and for the healthcare operations of St. Elizabeth Physicians.

I consent to receive communications at the phone numbers and address identified above. These communications may include, but are not limited to, live or prerecorded voices or text messages, letters, and may come from St. Elizabeth Physicians, its affiliates, its associates, business associates, or other third parties acting on St. Elizabeth Physicians behalf. Message and data rates may apply.

I further authorize the access of my clinical and medication information for treatment by St. Elizabeth Physicians and to any and all providers directly involved in my care.

Signature X_____ Date_____

(Signature of patient or patient representative)

Witness _____