PEDIATRIC & INTERNAL MEDICINE CENTER

Reid Physician Associates

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PATIENT REGISTRATION FORM – PLEASE COMPLETE IN FULL

Date_________________

Patient Name (first, middle, last): ______________________________ Sex: **M F**

Social Security #: __________________ Date of Birth: ________________ Marital Status: **S M D W**

Patient Address: ________________________City:____________State:_______Zip:________

Phone Numbers: (H) ________________(C)_________________(W)_________________

Employer Name:_____________________________ Status: **Full-Time Part-Time Retired None**

Employer Address: ______________________City:____________State:_______Zip:________

Student Status if applicable: **Full-Time Part-Time** Name of College/Univ/School.:__________________

In case of emergency, please list two people we may contact:

Name:____________________ Relationship:________________ Phone:______________

Patient Address: ________________________City:____________State:_______Zip:________

Name:____________________ Relationship:________________ Phone:______________

Patient Address: ________________________City:____________State:_______Zip:________

Primary Insurance Co.:____________________ Policy/ID #:____________ Group #:_________

Insured Party: **Self Spouse Parent**

Secondary Insurance Co.:__________________ Policy/ID #:____________ Group #:_________

Insured Party: **Self Spouse Parent**

Insured Party Information if not Self

Spouse/Parent Name:________________ Date of Birth:_______ Social Security #:______________

Employer:_________________________________ Work Phone #____________________

Employer Address: ______________________City:____________State:_______Zip:________

PLEASE SEE BACK OF PAGE FOR ADDITIONAL INFORMATION AND SIGNATURE REQUIREMENTS

GENERAL CONSENT FOR TREATMENT

I, the patient, or his or her representative, recognize the need for medical and hospital care, authorize Reid Physician Associates, Inc., its health care employees, allied health personnel and physicians to render such routine non-invasive medical/surgical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of the physician. This form is to provide authorization for "routine" services only and not for complex diagnostic or therapeutic procedures. Except for emergency or extraordinary circumstances, it is my understanding that additional consents will be obtained by the treating physician if more invasive services are to be performed.

I understand and am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee has been made to me as to the result of treatment or examination.

I understand that it is my right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I, the patient, or his or her representative, authorize my physician to release information from my medical record to my insurance carrier(s), and/or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

FINANCIAL AGREEMENT

I, the patient, or his or her representative, recognize that I have read, understood and received a copy of the Reid Physician Associates Financial Policy. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. I am aware and agree there will be a monthly finance charge of 1.5% on any unpaid balances 90 days and over. In addition, I designate your office, employees, and agents as my representative to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

PRIVACY PRACTICES

I, the patient, or his or her representative, acknowledges that I have received a copy of Reid Physician Associates, Inc., an Affiliated Covered Entity of Reid Hospital and Health Care Services, Notice of Privacy Practices.

I hereby certify that the information I provided on this form is true and accurate, I have read and understand the statements contained on this form, and I have received a copy of the Notice of Privacy Practices.

____ ____________________

Patient / Responsible Party Signature Date

MEDICARE/MEDIGAP AUTHORIZATION (if applicable)

I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to ____________________ *(name of practice/provider)* for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to__________________________(name of Medigap insurer) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

____ ____________________

Patient / Medicare Beneficiary Signature Date

CONSENT FOR MEDICAL TREATMENT OF A MINOR (if applicable)

I (we) the undersigned parent, parents, or legal guardian of ___________________, a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of ____
a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions:____

____ ____________________

Parent or legal guardian signature Date