Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Family Physician:	Date of Birth:		Sex: ☐ Male ☐ Female
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:	
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

☐ I certify that I have read and agree to Magnolia Endocrinology's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Magnolia Endocrinology to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds.

☐ I choose to receive communications from Magnolia Endocrinology by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on Magnolia Endocrinology's Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Magnolia Endocrinology. I authorize Magnolia Endocrinology to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

☐ **I have reviewed a copy of Magnolia Endocrinology's Privacy Notice and Office Policies.**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

Consent for Treatment, Authorization, Assignment of Benefits and Referral Release

Consent for Treatment: I consent and Authorize Magnolia Endocrinology providers or designated qualified assistants to provide Medical Treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Magnolia Endocrinology Notice of Privacy Practices, a copy of which has been made available to me.

_____

Authorization for Release of Medical Information: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

_____

Assignment of Insurance Benefits: I hereby assign all of my rights and allow payment to be made directly to Magnolia Endocrinology for all medical or surgical benefits otherwise payable to me under terms of my insurance.

_____

Payment Guarantee: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles and non-covered services rendered by Magnolia Endocrinology, including charges for services not covered by my insurance. I consent and authorize Magnolia Endocrinology and third-party agents of Magnolia Endocrinology to contact me by telephone at any number associated with me and to use a pre-recorded and /or automated dialing service in connection with any communication made to me or related to my account.

_____

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep Magnolia Endocrinology informed of ***changes to my contact information and insurance information***. A failure to keep Magnolia Endocrinology informed may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient's Signature: _____ Date: _____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____ Date: _____

_____

Ongoing Communication Regarding Your Healthcare

List any individual or provider below whom you authorize Magnolia Endocrinology to release or discuss your health information with. If you need additional spaces, request additional pages from the office staff.

Name: _____ Phone Number: _____

Relationship: _____ Address: _____