Patient Registration Form

Today's Date:		Primary Care Provider:	
Patient Information			
Patient's last name:	First:	Middle Initial:	Marital status:
Maiden name:	Date of Birth:	Age:	Gender: ☐Male ☐Female
Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refused to Answer		Race:	
Address:	City:	State:	Zip:
Social Security #:	Home phone #:	Cell phone #:	
Email Address:			
How did you learn about our services?			
Billing or Insurance Information			
(Please give your insurance card to the receptionist.)			
Are you insured? ☐ Yes ☐ No			
For Self-Pay and Uninsured Patients:			
Guarantor (First, MI, Last):			
Relationship to patient:	Date of Birth:	SS#:	
Address:	City:	State:	Zip:
Email Address:		Phone:	
Primary Insurance:			
Insurance Company Name:		Insurance Phone #:	
Insurance Company Billing Address:	City:	State:	Zip:
Insurance Effective Date:			
Subscriber's name (First, MI, Last):		Patient's relationship to Subscriber:	
Group Number:		Policy Number:	
Date of Birth:		SS#:	
Secondary Insurance (if applicable):			
Insurance Company Name:		Insurance Phone #:	
Insurance Company Billing Address:	City:	State:	Zip:
Insurance Effective Date:			
Subscriber's name (First, MI, Last):		Patient's relationship to Subscriber:	
Group Number:		Policy Number:	
Date of Birth:		SS#:	
In Case of Emergency			
Contact Name:	Relationship to patient:	Home phone #:	Cell phone #:

Please carefully review the following information and sign as appropriate.

I authorize release of medical information to my *insurance carrier and to my physicians when applicable*.

Patient Name (please print):	Patient Signature:	Birth Date:	Today's Date:

I hereby give the Jefferson County Health Department permission to provide information to:

_____ _____

Full Name of Representative Relationship

regarding the following:

- □ My entire medical record (excluding HIV results).
- □ My billing record(s) and/or balance due.
- □ Dates and times of past and future appointments
- □ This representative is allowed to pick-up my medications.
- □ I understand I may revoke this permission by submitting a written request to JCHD at any time.

Patient Name (please print):	Patient Signature:	Birth Date:	Today's Date:

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information (HIPAA): I, the undersigned patient, or personal representative of the patient named below, acknowledge that I have read and been offered a copy of Jefferson County Health Department's current *Notice of Privacy Practices for Protected Health Information* on the date set forth below. [45 CFR164]

Consent to Medical Care: I request and consent to the medical care and diagnostic treatment procedures as determined necessary by my physician(s) or his/her assistants. I acknowledge the care I receive while in this facility is under the direction of my physician(s). I understand the benefits and risks and hereby consent to vaccines, evaluation, testing, and treatment by my Jefferson County Health Department physician and his/her designee.

Payment for Medical and Related Care: I agree to pay the facility's set and established charges incurred for the care I receive as ordered by my physician(s) at this facility, including separate charges by independent contractors (such as labs). I guarantee full payment of all charges unless restricted by Medicare or Medicaid.

Assignment of Benefits: I hereby assign all of my rights and benefits under my existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatments rendered by the facility, affiliated physicians, and/or other independent contractors, and authorize direct payment to these parties for such services and treatment. I understand that most health insurance policies, including Medicare and Medicaid, are secondary payers to any existing liability policies, no-fault insurance, workers compensation or any other sources of payment that may or will cover expenses incurred for services and treatment.

I hereby appoint the facility, affiliated physicians, other independent contractors and any agent acting on their behalf as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies on my behalf for the collection against any responsible payer or third party liability carrier of any and all benefits due me for the payment of charges associated with my treatment.

Communication Concerning Services and Debt Collection: I authorize this facility to communicate with me for any reason related to the provision of services, including collection of amounts owed for services, using text messaging services, an automated telephone dialing system or prerecorded voice at the telephone number(s) I provided, including a telephone number assigned by a cellular telephone service or any service for which I am charged for the call. In addition, I consent to and agree that any calls between this facility and I may be monitored and/or recorded for any purpose. If debt collection becomes necessary, I also authorize this facility, including any collection agency or debt collector hired by this facility to check my credit and employment history, obtain a copy of my consumer report and obtain personal information from any consumer reporting agency. In the event your account goes to an outside collection agency we will add 28% collection fee to any outstanding balance due.

Payment for Minors: If a minor is brought in for services by someone other than the parent, custodial parent, legal guardian, etc. the charges are to be paid at the time of service by the person bringing the child in. In the case of non-custodial parent having responsibility for medical bills, the person bringing the child in must pay at the time of service and make their own arrangements with the responsible party for reimbursement. I assume responsibility for payment of charges not covered by my insurance, ***unless I am a minor seeking confidential services***.

Acknowledgment and Certification: By signing this form, I certify that I am the patient or the patient's legal representative, I have read this Conditions of Treatment Form, I was given the opportunity to ask questions and I understand and accept all terms herein.

Patient/Guardian signature:	Date:
Relationship to Patient:	JCHD Staff Initials and Date Entered: