MERCYHEALTH Physicians

PATIENT REGISTRATION FORM

First Name_____ MI_____Last Name_____Date of Birth _____

Address _____ City_____State _____ZIP_____

Home Phone (___)_____Cell Phone (____) _____Work Phone (___)_____

SS#_____-_____-_____ Sex: **M** **F** Email Address:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian and Alaska Native ☐ Bi-Racial ☐ Middle Eastern ☐ Hawaiian/Pacific Islander
☐ Black or African American ☐ White/Caucasian ☐ Other ☐ Unknown

Employed: **Y / N** **PT / FT** Employer:_____ Address:_____

Marital Status: **M** **S** **D** **W** **Sep** **SO** Spouse Name_____Spouse DOB _____

How did you hear about us?_____

Advance Directives: Do you have a Living Will? ☐ Yes ☐ No Preferred Language _____

Emergency Contact: Name_____Relationship _____Phone (____) _____

If the Patient is NOT the Subscriber (person who carries insurance) please provide additional information requested below:

Primary Insurance:_____Subscriber Name:_____Relationship:_____

DOB: _____Employed: **Y / N** **PT / FT** Subscriber Name of Employer:_____

Secondary Insurance: _____Subscriber Name:_____Relationship: _____

DOB: _____Employed: **Y / N** **PT / FT** Subscriber Name of Employer: _____

If you have MEDICARE, please also complete the questions on the back of this form

Primary Care Physician:_____Address:_____Phone:(____) _____

Referring Physician: (if applicable)_____ Phone (____) _____

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

1. _____I have given the office my current and correct insurance information.
2. _____ I understand that I could be ***charged $25 for a missed appointment (no show)*** if a 24-hour notice of cancellation is not given.
3. _____ I understand that I could possibly be discharged from the practice for failing to give 24 hour cancellation notice for three or more scheduled appointments.
4. _____ I understand that my co-payment is due at each visit and a ***$15 administration fee*** will be charged to me, if this agreement is not met.
5. _____ I understand that I may be responsible for charges related to the completion of forms and letters. (Fee schedule will be provided by the office)

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

_____ _____

Signature of Person Responsible Date

MEDICARE QUESTIONAIRE

If you have Medicare, please answer the following questions:

1.) Are you receiving Black Lung Benefits (BL)? □Yes □No

2.) Are the services to be paid by a government research program? □Yes □No

3.) Are you entitled to benefits through the Department of Veterans Affairs (DVA)? □Yes □No

4.) Was the illness/injury due to a work-related accident/condition? □ Yes □No

5.) Are you entitled to Medicare based on Age? □Yes □No

6.) Are you entitled to Medicare based on Disability? □ Yes □No

7.) Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? □ Yes □No

MERCYHEALTH
Physicians

January 1, 2013

Dear Patient,

Thank you for choosing Mercy Health Physicians to help you Be Well. As healthcare expenses continue to rise we are making a few adjustments.

Starting January 1, 2013 there will be important changes in fees for completion of patient forms and letters. Please see the three levels below.

There will be no charge for forms completed during a scheduled office visit.

LEVEL	DESCRIPTION	CHARGE PER FORM	FORM EXAMPLES
LEVEL 1	No Charge	$0.00	Handicap Placard, Work/School Excuse, Utilities, Daycare Immunization Record
LEVEL 2	Simple	$20.00	Sports Physicals, Pre-employment, Insurance, Health Club Enrollment
LEVEL 3	Complex	$35.00	FMLA, Disability

- Patients are responsible for completing and signing their portion of forms in order to process.
- Forms may take up to 7 business days to complete.
- Due to HIPAA laws and regulations, forms cannot be faxed.
- Completed forms must be picked up at the office or mailed to a verified address.
- The office will call you when the forms are complete, so please be sure to provide an accurate phone number to reach you.

Please contact our office with any questions or concerns you may have.

Sincerely,

Mercy Health Physicians

MERCYHEALTH

Communication Release of Information

The Privacy Rule generally requires healthcare providers to take reasonable steps to minimize the Protected Health Information (PHI) requests, usage and disclosure for only what is required to meet the intended need. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in a medical emergency.

_____ **DO NOT PROVIDE health information regarding blood work, appointments, and test results to anyone but me.**

_____ **I give permission to receive my health information regarding normal test results in a voice mail message.**

Authorized Representatives

I give permission for the following people listed to receive the following PHI elements as specified below.

Name_____**Relationship**_____**DOB**_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results_____Discuss my condition and treatment

Name_____**Relationship**_____**DOB**_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results_____Discuss my condition and treatment

Name_____**Relationship**_____**DOB**_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results_____Discuss my condition and treatment

Name_____**Relationship**_____**DOB**_____

Contact Telephone #_____

___ Appointments ___Billing ___Test Results_____Discuss my condition and treatment

My signature below acknowledges that I provided the information above.

Signature of Patient/Legal Guardian_____**Date** _____