



Patient Registration and Insurance Information Form

**Patient Information**

Patient Legal Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender \_\_\_\_\_

Preferred way to be addressed (Mr. Smith, Bob, Ms. Smith etc): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address (if different from mailing address): \_\_\_\_\_

Home phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Preferred alternative contact number (circle type: cell phone, work phone, message phone): (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Insurance Information**

Primary Insured's Legal Name (under whose name is the insurance e.g. spouse's name, mother's name, father's name, etc): \_\_\_\_\_

Primary Insured's date of birth: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Subscriber ID number (found on the insurance card): \_\_\_\_\_

Co-Pay for office visits (found on the insurance card, if none write 0): \_\_\_\_\_

**Important and emergency contacts**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Primary contact phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Alternate contact phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Parent / Guardian / Spouse / Partner contact information** (please list all

Parents/Guardians if more than one)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Alt. phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Name: \_\_\_\_\_

Address (if not the same as 1<sup>st</sup> listed: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Alt. phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Guarantor** (the financially responsible person/party, it can be self):

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_



## **Consent for Treatment and Payment and Privacy Policy Acknowledgement**

**Consent to Medical Care:** The undersigned consents to any laboratory, imaging, anesthetic, medical, surgical, or emergency treatment and/or clinic services rendered under the instruction of the provider. The patient understands that no guarantee or assurance has been made as to the results that may be obtained during the treatment.

**Release of Patient Information:** The undersigned hereby consents that Chad Magnuson Family Medicine may release to the guarantor's insurance company, or any third party payer, pertinent information related to the medical treatment including: HIV testing and treatment, psychiatric, alcohol and drug treatment records in order to secure contractual payments for services rendered.

**Assignment of Insurance Benefits:** In the event the patient is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, such benefits are hereby assigned to Chad Magnuson Family Medicine for application to patient's bill. The patient may be responsible for 100% of charges not covered by this assignment. Patients eligible for Medicare hereby authorize Chad Magnuson Family Medicine to bill and collect from Medicare directly. Any charges not covered by Medicare or any supplementary insurance may be the responsibility of the patient.

**The Undersigned Certifies:** that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as his/her legal representative to execute the above and accept its terms.

Patient Name \_\_\_\_\_

x \_\_\_\_\_  
Patient's Signature                      Date

x \_\_\_\_\_  
Patient's Representative's Signature    Date

Relationship to patient \_\_\_\_\_

Is patient a minor? Yes\_\_ No\_\_

**Permission to Treat Minors:** I, the undersigned, give permission to Chad Magnuson Family Medicine to treat \_\_\_\_\_ for any medical or surgical problem that may arise during my absence.

Effective date of treatment: From \_\_\_\_\_ to \_\_\_\_\_

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Chad Magnuson Family Medicine, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name



### Consent for Communication

Authorization to leave Personal Health Information by alternate means (please check all that apply):

- May leave detailed message on voice mail at home
- May leave detailed message on voice mail at work
- May leave appointment information with spouse/partner \_\_\_\_\_
- May leave appointment information with other family member(s) \_\_\_\_\_
- May leave detailed message on cellular phone # \_\_\_\_\_
- May leave message at a different location \_\_\_\_\_
- May leave message to call Chad Magnuson Family Medicine

Request for limitations and restrictions of Personal Health Information (please check all that apply):

- Do not call home phone number
- Do not use home address
- Do not call me at work
- Do not release information to \_\_\_\_\_
- Other \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date