IU HEALTH SOUTHERN INDIANA PHYSICIANS PATIENT REGISTRATION

Name LAST: **FIRST:** **MIDDLE:**

SS #: **BIRTH DATE:** **GENDER:** □**MALE** □**FEMALE**

ADDRESS LINE 1: **LINE 2:**

CITY: **STATE:** **ZIP:**

PHONE # HOME: **WORK:** **CELL:**

EMAIL ADDRESS:

EMPLOYER NAME: **PHONE:**

PRIMARY CARE PROVIDER:

MARTIAL STATUS □ SINGLE □MARRIED □DIVORCED □WIDOWED □ SEPARATED

RACE □ BLACK/AFRICAN AMERICAN □ WHITE □ASIAN □NATIVE HAWAIIAN □AMERICAN INDIAN/ALASKA NATIVE □MIXED RACE □OTHER PACIFIC ISLANDER □ OTHER

ETHNICITY □ HISPANIC/LATINO □NOT HISPANIC/LATINO

PRIMARY LANGUAGE SPOKEN □ ENGLISH □SPANISH □FRENCH □CREOLE □OTHER (PLEASE LIST)

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

RELATIONSHIP TO PATIENT □ PARENT □ LEGAL GUARDIAN □ POA □ OTHER

NAME LAST: FIRST: MIDDLE:

SS #: **BIRTH DATE:** **GENDER:** □MALE □FEMALE

ADDRESS □ CHECK IF SAME AS PATIENT LINE 1: LINE 2:

CITY: **STATE:** **ZIP:**

PHONE # HOME: **WORK:** **CELL:**

EMPLOYER NAME: **PHONE:**

ADDRESS:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: **PHONE:**

INS ADDRESS:

POLICY HOLDER/SUBSCRIBER NAME: **SUB BIRTH DATE:**

RELATIONSHIP TO PATIENT □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER **GENDER**: □MALE □FEMALE

POLICY HOLDER INFORMATION ADDRESS: **PHONE:**

SUBSCRIBER/ MEMBER ID # **GROUP #**

EMPLOYER NAME:

SECONDARY INSURANCE NAME: **PHONE:**

INS ADDRESS:

POLICY HOLDER/SUBSCRIBER NAME: **SUB BIRTH DATE:**

RELATIONSHIP TO PATIENT □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER **GENDER**: □MALE □FEMALE

POLICY HOLDER INFO ADDRESS: **PHONE:**

SUBSCRIBER/ MEMBER ID # **GROUP #**

EMPLOYER NAME:

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME: **RELATIONSHIP:** **PHONE:**

OTHER INDIVIDUALS AUTHORIZED TO RECEIVE INFORMATION ABOUT THE PATIENT:

OTHER FAMILY MEMBERS WHO ARE PATIENTS OF THIS OFFICE:

MAY WE LEAVE A MESSAGE ON YOUR VOICEMAIL AND/OR ANSWERING MACHINE: □YES □NO

AUTHORIZATION TO PAY BENFITS TO PHYSICIAN AND TO RELEASE INFORMATION: I hereby authorize payment to my provider for Medical Services rendered. I also realize that I am responsible to pay all non-covered services rendered. I authorize my Provider to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature_____ **Date**_____

Medicare Patients Only: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my provider who treats me to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I authorize payment of benefits to be make directly to my provider treating me on my behalf.
Initial_____

Consent To Treat: I request and give consent to my provider to provide and perform such medical/surgical care, test, procedure, drugs and other services and supplies as are considered necessary or beneficial for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me.
Initial_____

Release of Medical Information and Authorization to Pay Insurance Benefits: I authorize my provider to release information from my medical record to my insurance carrier(s), 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 assigned insurance benefits directly to my provider on my behalf.
Initial_____

Financial Agreement: I understand all accounts are the full responsibility of the patient and/or the responsible guarantor. My provider will assist patients in obtaining insurance benefits when those benefits are assigned to my provider. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my provider. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to collect any outstanding balances on my account.
Initial_____

HIPAA Information: I acknowledge that I have been offered a copy of this office's HIPAA Notice of Privacy Practices. This notice describes how medical information about me may be used and/or disclosed and how I can access this information. The Notice of Privacy Practices is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance.
Initial_____

Responsible Party Signature_____Date_____

Patient Name_____