PATIENT REGISTRATION INFORMATION

(PLEASE PRINT)

PATIENT DEMOGRAPHIC/CONTACT INFORMATION

Last Name:________________ First Name:________________ Middle In:__________ Sex: M F

Address:____________________________________ Social Security #:________________

City:________________ State:______ Zip:_______ D.O.B.________________

Home Phone: ( ) Cell Phone: ( ) Business Phone: ( )

OK to leave message? Yes No OK to call? Yes No Ok to call? Yes No

Marital Status: Single Married Other Employment Status: Employed Retired Student

(circle one) (circle one)

Emergency Contact Person: ________________ Phone:( )________ Relationship:____________

Place of Employment: ____

Work Address: ____

How did you hear about us: □ TV □ Radio □ Newspaper □ Friend/Relative □ Other ____________

FINANCIAL INFORMATION

How will you be paying for today's visit? Personal Check Cash Credit Card Debit Card

Private Insurance (please complete the following)

Insurance Plan: ____________________ Effective Date:____________________

Address: ____________________ City/State/Zip: ____________________

ID Number: ____________ Group Name: ____________ Group Number: ____________

Policyholder's Information: Name: ________________ Social Security #:________________

Date of Birth: ____________ Relationship to patient: ________________

Please review and sign the reverse side.

All sections must be filled in for registration to be complete.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

_____/______/_____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

TREATMENT CONSENT:

Medical services rendered at RGV Preventative Care are considered office visits. All imaging and radiological services are considered procedures. Office Visit is defined as medical, surgical, and related healthcare services for the evaluation and treatment of an injury or illness, which a layperson feels requires prompt evaluation and treatment by a healthcare professional.
I understand that by signing in for evaluation at RGV Preventative Care, I am seeking medical services.

MEDICAL AND SURGICAL CONSENT:

The signer or his/her dependent is suffering from a condition requiring diagnosis and medical treatment. The signer, does hereby voluntarily agree to diagnostic procedures and services and medical and/or surgical treatment which may be administered to or performed on the patient or his/her dependent under the instruction of the attending physician by the physician, his or her assistants or is or her designees.

RELEASE OF INFORMATION:

The signer authorizes the physicians at RGV Preventative Care to disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physicians of RGV Preventative Care or to the patient or the employer of the patient for all or part of the physicians charges for its services including but not limited to worker's compensation carriers, insurance companies, welfare funds, or the patient's employer. I understand that following the release of these records neither RGV Preventative Care nor its physicians will be responsible for the confidentiality of any documents released in accordance with this consent.

PATIENT AGREEMENT:

Payment for services is expected at time and date that services are rendered. If we file a claim with your insurance carrier, you will be responsible for any co-payment, deductible, and for any services not covered by your insurance company. It is the responsibility of the patient or his/her guardian to verify covered benefits (i.e. imaging/radiology benefits) with your insurance carrier. If we file a claim for work related or auto accident related injuries and the claim is denied, you will be responsible to pay the bill in full. A $25.00 fee will be assessed for any returned checks. Unpaid balances may be sent to an independent collection agency if not paid in a timely manner. Interest may be included for any outstanding fees.

I have read the about Acknowledgments and Agreements, and fully understand the same.
I attest that above information is true and correct to the best of my knowledge.
I understand this treatment consent applies to this visit and all future visits.

Signature of Patient ______________________________

Signature of Guardian ______________________________

Guardian's relationship to patient ______________________________

Date ____________________ **Time** ____________________

Telephone permission granted by (if guardian not present) ____________________

Witness ____________________ **Date** ______________