Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Date of Birth:			Sex: ❑ Male ❑ Female
Marital Status:			Social Security #:
Employer Name:			Emergency Contact Name:
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Provider Information

Primary Care Physician	**Referring Physician**
Mailing Address	Mailing Address
City/State/Zip	City/State/Zip
Office Phone #	Office Phone

Sharing Health Information Consent

Sharing of Your Health Information

I give permission to the physicians and their staff at Lake Russell Specialty Healthcare Services to share my health information including results, diagnoses, and appointment information with the following person(s).
The person(s) you list will also be permitted to pick up prescriptions on your behalf if you are unable.

NAME	RELATIONSHIP	PHONE NUMBER

Consents

Treatment Consent

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of Lake Russell Specialty Healthcare Services who may attend me, their assistants, including those employed by Lake Russell Specialty Healthcare Services to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

(Initials) _____

Release and Assignment of Benefits

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Lake Russell Specialty Healthcare Services to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Lake Russell Specialty Healthcare Services and/or its physician's any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Lake Russell Specialty Healthcare Services, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Lake Russell Specialty Healthcare Services and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to LRSHS. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

(Initials) _____

Communication and Photo Consent

I authorize Lake Russell Specialty Healthcare Services to contact me on any cell phone number provided by me by voice or text for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose.

I consent and give permission to Lake Russell Specialty Healthcare Services to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

(Initials) _____

I have received a copy of Lake Russell Specialty Healthcare Services' Practice Policies and Guidelines and Financial Policy ☐ **(Initials)**

I have reviewed a copy of Lake Russell Specialty Healthcare Services' Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____