Premier Health
Premier Physician Network

Registration Form

PATIENT INFORMATION:

*Patient Name: ______________________________ *SS #: ______________
Last First Full Middle 123-45-6789

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ Aliases/Nicknames: ______________

*Street Address/PO Box: ______________ *City, State Zip: ______________

County: ________ *Home Phone: (____)________ Work Phone: (____)________ Cell Phone: (____)________

Email Address: ______________ Marital Status: ☐Married ☐Widowed ☐Single ☐ Divorced ☐Legally Separated ☐Significant Other

*Occupation: ______________

*Employer: ______________ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: ______________

Name of Legal Guardian: ______________ Referring Physician: ______________

Ethnic Group: ________ Preferred Language: ________ Race: ________ Religion: ________

Special Needs: ☐Hearing ☐Language ☐Speech ☐Vision ☐Multiple Needs ☐No Special Communication Needs ☐Other

Primary Care Physician: ______________

EMERGENCY PATIENT CONTACTS:

Name: ____________ Phone: (____)________ Alternate Phone: (____)________ Relation to Patient: ________

Name: ____________ Phone: (____)________ Alternate Phone: (____)________ Relation to Patient: ________

RESPONSIBLE PARTY (GUARANTOR): *Check if Same as Patient ☐

*Relation to Patient: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

*Name: ______________________________ *SS #: ______________
Last First Full Middle 123-45-6789

*Street Address/PO Box: ______________ *City, State Zip: ______________

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)________ Work Phone: (____)________

*Employer: ______________ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: ______________

*City, State Zip: ______________

ADVANCED DIRECTIVES: (circle if applicable)

Do you have an advanced directive? Living Will: ☐Y / ☐ N DNR: ☐Y / ☐N Durable Power of Attorney for health care: ☐Y / ☐N

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐CareFinders ☐Friends/Family ☐Physician ☐Advertisement Other ______________

PLEASE COMPLETE INSURANCE INFORMATION ON THE REVERSE SIDE

*Required Field

INSURANCE/POLICY HOLDER INFORMATION (SUBSCRIBER):

Please present insurance cards to receptionist

*Name: ____ *SS #: ____________________
Last First Full Middle 123-45-6789

*Street Address/PO Box: ______________________________ *City, State Zip: ______________________

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)__________ Work Phone: (____)__________

*Employer: ______________________ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: ______________________

*City, State Zip: ______________________

*Primary Insurance: ______________________________ *Effective Date:____/____/____

*Member ID: ______________________ *Group Number: ______________________

*Patient Relation to Subscriber: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

*Relationship to Guarantor: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

SECONDARY INSURANCE:

*Name: ____ *SS #: ____________________
Last First Full Middle 123-45-6789

*Street Address/PO Box: ______________________________ *City, State Zip: ______________________

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)__________ Work Phone: (____)__________

*Employer: ______________________ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: ______________________

*City, State Zip: ______________________

*Secondary Insurance: ______________________________ *Effective Date:____/____/____

*Member ID: ______________________ *Group Number: ______________________

*Patient Relation to Subscriber: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

*Relationship to Guarantor: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

Authorization for Treatment and Disclosure of Information for Treatment, Payment, and Operations

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Premier Physician Network (PPN). I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to PPN using and disclosing my protected health information to carry out treatment, payment, or health care operations.

PPN and Premier Health may use any information provided on this form to communicate with me.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PPN reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying PPN in writing, except to the extent that Premier Physician Network has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PPN any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to PPN of all insurance benefits and agree to pay any balance due. I agree, in order for PPN to service my account or to collect any amounts I may owe, PPN may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, and may also contact me by sending text messages or e-mails, using any e-mail address I provide to use which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

______________________________ ______________/______________
Signature of patient or patient's representative Date Date of Birth

______________________________ ______________________________
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.

*Required Field