PLEASE PRINT CLEARLY

PATIENT REGISTRATION FORM

Please provide your insurance card and picture ID to the receptionist

Today's Date:

Primary Provider:

PATIENT DEMOGRAPHIC INFORMATION

Last Name: First Name: Middle:

Preferred Name: Maiden Name: Prefix (circle one) Miss Mr. Mrs. Ms. Suffix (circle one) N/A I II III IV Jr. Sr.

Date of Birth: Sex: Race:

Martial Status: SS# Primary Language:

Ethnicity: (Circle One)
Decline Hispanic/Latino Not Hispanic/Latino Unknown

Address:

Zip: City: State: County:

Home Phone: Work Phone: Cell Phone: Primary Number:

Email address:

Is it ok to leave a message at HOME Y___N___ CELL Y_____N_____

Fax #:

Preferred Communication: (circle one) Home Cell Mail Text Email Patient Portal

Employer: Occupation: Phone #:

ASSOCIATED PARTY/EMERGENCY CONTACT

Last Name: First Name: Date of Birth

Address: City: State: Zip:

Home Phone #: Alt. Phone #: Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member's ID #: Group #	Member's ID #: Group #
Name of Policy Holder:	Name of Policy Holder:
Relationship to Patient:	Relationship to Patient:

If Policy holder is other than patient, please complete following information:

Policy Holders Name: Social Security # Date of Birth

Address: City: State: Zip:

Phone Number: Alt. Phone Number: Employer:

Primary Pharmacy Name/Number: _____ Initial: _____

SIGNATURE SECTION

To the best of my knowledge, the information on the registration form is complete and correct. I understand that it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature:_____ **Date**:_____

CONSENT TO TREATMENT

I voluntarily consent to medical care at **Consolidated Medical Practices of Memphis** for routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistance, medical assistants, or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at **Consolidated Medical Practice of Memphis.**

I promise as a patient of **Consolidated Medical Practices of Memphis** to I will follow all office policy that pertain to the patients of the office. I understand that if I am not compliant with following the physicians' plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature:_____ **Date**: _____

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers, and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature:_____ **Date**: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize **Consolidated Medical Practice of Memphis** or its agents to furnish information to Medicare, insurance carriers or other third-party payers concerning my illness and treatment. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that co-pays and/or deductibles are due at time of service, unless other arrangements are made prior to services being rendered. I understand that I am financially responsible for the services rendered to me and/or my dependents. In those cases where payment is not collected at time of service, I understand that I am responsible for the cost of all medical services rendered and agree to pay any and all amounts not paid by others within thirty (30) days from the date billed, unless there are other arrangements between me and my insurance company and/or Consolidated Medical Practices of Memphis. I agree to pay all collection costs, including, but not limited to, court costs, witness expenses and reasonable attorney's fee if it becomes necessary to turn this account over to an outside party for collections.

Patient/Responsible Party: _____ **Date:** _____

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of **Consolidated Medical Practice of Memphis** to speak with the following people regarding insurance and billing concerns.

Name:_____ Phone #:_____ Relationship:_____
Name:_____ Phone #:_____ Relationship:_____
Name:_____ Phone #:_____ Relationship: _____

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding my health care, plan of treatment, medications, and lab/test results.

Name:_____ Phone #:_____ Relationship:_____
Name:_____ Phone #:_____ Relationship:_____
Name:_____ Phone #:_____ Relationship: _____