PATIENT REGISTRATION

Story Medical CLINICS

☐ Nevada *ph* 515-382-5413 *f* 515-382-7107 ☐ Maxwell *ph* 515-387-8815 *f* 515-387-8817 ☐ Slater *ph* 515-685-3960 *f* 515-685-3961 ☐ Zearing *ph* 641-487-7779 *f* 641-487-7749

Anyone 18 years or older will be considered an adult and placed on their own account

Patient

Legal name: _____ SS#: _____
First Middle Last

Legal Guardian(if under 18): _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: ( )_____ ☐ Male ☐ Female Student: ☐ Yes ☐ FT ☐ PT ☐ No

Work ph: ( )_____ Cell ph: ( )_____ Employer: _____

Marital status: M S D W Referring provider: _____ Primary provider: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

If Married

Spouse's name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work ph: ( )_____ Cell ph: ( )_____

In case of emergency, name of person NOT living with patient to contact:

Name: _____ Phone: _____ Relationship to patient: _____

INSURANCE INFORMATION

Please give us all pertinent information regarding your insurance coverage and present a copy of your card to the receptionist.

Primary Insurance:

Insurance name: _____

Person carrying ins: _____

DOB: _____

Address of person carrying ins: _____

_____

Relationship to patient: _____

ID No: _____ Group No: _____

Effective date: _____

Secondary Insurance:

Insurance name: _____

Person carrying ins: _____

DOB: _____

Address of person carrying ins: _____

_____

Relationship to patient: _____

ID No: _____ Group No: _____

Effective date: _____

Other Info

I give permission to be contacted at the following phone numbers: ☐ Home ☐ Work ☐ Cell

I give permission to (please check all that apply):

☐ Leave a message regarding medical information (i.e. test results, prescription information, etc.).

☐ Leave a message regarding upcoming appointments.

I give permission for the following people to discuss my:

☐ Billing statements: _____

☐ Medical records: _____

Signature: _____ Date: _____

Clinic Use Only

MR No: _____

Updated/Review Initial/Date: _____ Initial/Date: _____ Initial/Date: _____

***If the patient's information has changed, please ask them to fill out a new form.**

Nevada, Maxwell, Zearing, and Slater Medical Clinics are affiliates of Story County Medical Center

PATIENT REGISTRATION
(CONTINUED)

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INSURANCE INFORMATION

If you have insurance, you must allow us to make a copy of your insurance card(s). If you do not have insurance, or if you fail to provide us with a card that we can copy, you will be held financially liable for the full charges. Payment is due at the time of services rendered.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the above named clinic for any services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorized releasing of the information to the other insurer or agency. In Medicare-assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Medicare patients _____ Date _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED WHETHER OR NOT THEY ARE COVERED BY INSURANCE. ASSIGNMENT AND RELEASE OF INFORMATION (Must have patient's/parent's signature)

If I, the undersigned, have insurance coverage (or gain insurance coverage) during my healthcare period, assign directly to the above named clinic all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all my insurance submissions. I, the patient, am responsible for the deductible, coinsurance and uncovered services.

Signature of all patients (or parent if patient is a minor) _____ Date _____

PATIENT CONSENT FORM REGARDING NOTICE OF PRIVACY PRACTICES (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, the patient. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice you may obtain a revised copy by visiting our website or by requesting a copy from the clinic or medical center. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of all patients (or parent if patient is a minor) _____ Date

For Office Use Only

Name: _____

MR No: _____

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