PROVIDENCE MEDICAL GROUP

PATIENT REGISTRATION SHEET

Location _____ Doctor _____

Referring Physician _____ Family Physician _____

Patient's Name _____ (last) _____ (first) _____ (middle initial) Male ___ Female ___ Birthdate _____

Street _____ City _____ State _____ Zip _____ Age _____

Home Phone (____) _____ Cell/Pager/E-mail _____ Work (____) _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ SS# _____

Employer _____ (last) _____ (address) Phone (____) _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ (name) _____ (address) (____) _____ (phone#)

RESPONSIBLE PARTY 18 years or older (if different from patient) Relationship _____

Name _____ SS# _____

Street _____ City ____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____ (name) _____ (address) (____) _____ (phone#)

Primary Insurance Company _____

Claim Mailing Address _____ City _____ State ____ Zip _____

Phone (____) _____ ID# _____ Group# _____

Insured's Name _____ Relationship _____

Effective Date _____ through _____ SS# _____ Birthdate _____

Secondary Insurance Company _____

Claim Mailing Address _____ City _____ State ____ Zip _____

Phone (____) _____ ID# _____ Group# _____

Insured's Name _____ Relationship _____

Effective Date _____ through _____ SS# _____ Birthdate _____

Next of Kin (other than spouse) _____

Relationship _____ Phone (____) _____

I request that payment of authorized Medicare and/or private benefits be made either to me or on my behalf for any services furnished by the Providence Medical Group, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, or my private carrier information needed to determine these benefits or any benefits for related services. I request that payment of authorized MediGap benefits be made either to me or on my behalf to Providence Medical Group for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to (name of insurance company)_____ any information needed to determine these benefits or the benefits payable for related services.

I hereby agree to pay Providence Medical Group the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs, and collection agency fees, to which may be added pre-judgement and/or post-judgement interest at the current legal rate.

Signature _____ Date _____ Employee's Initials _____

(patient/parent if minor dependent)

PROVIDENCE MEDICAL GROUP,LLC.

Release of Protected Health Information

I _____ **hereby authorize Providence Medical Group to release/discuss my protected health information with the following people.**

Name	Relationship	Phone Number
1.		
2.		
3.		

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to Providence Medical Group. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to the authorization or to information that Providence Medical Group has used based on this authorization.

If I have questions about the use and disclosure of my information, I can contact Providence Medical Group at (812) 232-8164.

_____ _____

Patient Signature **Witness Signature**

_____ _____

Date **Date**

PROVIDENCE MEDICAL GROUP, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Providence Medical Group, LLC.

_____ _____

Patient/Authorized Representative Date

_____

Printed Name

Organization Use Only: _____

Date acknowledgment received: _____

OR

Reason acknowledgment was not obtained:

_____

_____

_____