Midway Medical Center, PA – New Patient & Information Change

Patient Information- Use full legal name Date ______________________

Last Name ____________________________________ First Name ________________________Middle Initial __________

Mailing Address ____

City ____ State ___________________ Zip ______________________

Primary Phone _______________________________________ Secondary Phone _________________________________

Date of Birth _________________________________ Age _______ Sex _________ Marital Status___________________

SS# _____________________________________ **Email Address**: ____

Ethnicity: Hispanic or Non-Hispanic Preferred Language ___________________ Race __________________________

Pharmacy Name & Location ____

Employer Name ____ Work Number _______________________________

Can we leave a message at: work Y or N home Y or N Cell Y or N

Emergency Contact Name and Number ____

Guarantor Information-Complete this section if patient is child under 18 or Insurance is through your spouse/partner

Relationship to patient: Spouse _________ Parent ________ Other _________

Last Name _________________________ First Name ____________________________ Middle Initial _______________

Address ____

City ____ State __________________ Zip __________________________

Home phone ____ Cell number _______________________________________

Date of birth of insured __________________________ Sex ___________ SS# ___________________________________

Employer Name ____ Work # ___________________________________

Insurance Information (do not complete if insurance cards were scanned) **Scanned Yes No**

Primary Insurance Co Name ____________________________________ Policy holder Name _________________________

Policy # ____________________________ Group # ________________ Policy holder DOB ___________________

Secondary Ins Co Name ____ Policy holder Name ________________________

Policy # __________________________ Group # ___________________ Policy holder DOB: __________________

Patient Privacy Directive

Person (s) who may have access to my medical information and/or pick up prescriptions:

Name _______________________________ Relationship ________________ phone ___________________ RX__ HIPAA __

Name _______________________________ Relationship ________________ phone ___________________ RX__ HIPAA___

Name _______________________________ Relationship ________________ Phone ___________________ RX__ HIPAA___

*****please read & sign back of form ******

PATIENT REGISTRATION FORM

DISCLOSURES AND CONSENTS

Patient Name: ____ Date of Birth: _________________
First Name MI Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Midway Medical Center, PA for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Midway Medical Center is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/TRICARE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Midway Medical Center, PA for the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Midway Medical Center PA Patient Information Privacy Policy. I hereby authorize Midway Medical Center, PA to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Midway Medical Center, PA representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Midway Medical Center, PA to that effect in writing.

LAB/X-RAY/DIAGNOSITIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Midway Medical Center, PA physician or his or her designee. I have read and understand the above statements.

PATIENT/PARENT OR GUARDIAN SIGNATURE: ____

DATE _____________