VICKERY FAMILY MEDICINE

Patient Registration Form (page 1 of 2)

PATIENT INFORMATION

Full Legal Name

Date of Birth

Social Security Number

Home Address

Employer

Employer Address

Home Phone

Work Phone

Mobile Phone

Email

Emergency Contact Name

Relationship to Patient

Emergency Contact Number

GUARANTOR INFORMATION

(person responsible for bill)

Full Legal Name

Date of Birth

Social Security Number

Home Address

Employer

Employer Address

Home Phone

Work Phone

Mobile Phone

Relationship to Patient

Is guarantor a patient with us?

☐ Yes ☐ No

VICKERY FAMILY MEDICINE

Patient Registration Form (page 2 of 2)

PRIMARY INSURANCE

Insurance Company Name

Insurance Company Phone Number

Policy Number

Group Number

Policy Holder

Policy Holder Social Security #

Policy Holder Date of Birth

Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name

Insurance Company Phone Number

Policy Number

Group Number

Policy Holder

Policy Holder Social Security #

Policy Holder Date of Birth

Relationship to Patient

HOW DID YOU FIND OUT ABOUT US?

- ☐ Friend or Family Recommendation
- ☐ Radio
- ☐ Insurance Company
- ☐ Physician Referral (please specify)
- ☐ Co-Worker or Employer
- ☐ Newspaper or Magazine
- ☐ Internet
- ☐ Other (please specify)

VICKERY FAMILY MEDICINE

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEES:

Name	Name
Name	Name
Name	Name
Name	Name

Patient Signature

Date

VICKERY FAMILY MEDICINE

Patient Information Consent Form

I have read and fully understood Vickery Family Medicine's Notice of Information Practices. I understand that Vickery Family Medicine may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Vickery Family Medicine will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Vickery Family Medicine's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I further authorize Vickery Family Medicine to leave messages regarding my protected health information at the following phone numbers or email addresses (please check Yes or No):

☐ Yes	☐ No	Home Phone
☐ Yes	☐ No	Work Phone
☐ Yes	☐ No	Mobile Phone
☐ Yes	☐ No	Email

Patient Signature

Date

VICKERY FAMILY MEDICINE

Consent to Treat, Release of Information, Assignment of Benefits, and Financial Responsibility

I hereby give my consent to all physicians of Vickery Family Medicine, PLLC, to provide treatment to the named patient. I hereby authorize Vickery Family Medicine, PLLC to obtain all necessary medical records from previous physicians, hospitals, clinics, surgery centers, and laboratories. I further authorize Vickery Family Medicine, PLLC to forward records of my evaluation and/or treatment to other treatment team physicians. I also authorize Vickery Family Medicine, PLLC to release all information necessary to file my insurance/Medicare claim and to allow a photocopy of my signature to be used to process my current and any future insurance/Medicare claims. I hereby assign insurance/Medicare benefits to be paid directly to Vickery Family Medicine, PLLC.

I understand that I am financially responsible for all charges incurred during the course of treatment, whether or not paid by any insurance. It is my responsibility to pay any deductible or co-payment amounts at the time of service. I also understand that I am responsible to obtain any authorizations necessary for services provided by Vickery Family Medicine, PLLC. I certify that the information provided on the patient registration forms is true and correct.

Patient Signature or legally authorized individual

Printed name

Relationship if signed on behalf of patient

Date