Rush Copley Medical Group Patient Registration Form Today's Date:

DEMOGRAPHIC INFORMATION

Patient Name: Date of Birth:
Marital Status: Social Security #:
Address:
City/State/Zip:
Home Phone: Cell Phone:
Employer Name: Work Phone:

Responsible Party Name: ______________________ Relationship: ________________

Social Security #: __________________ Home Phone:_____________ Birth Date: __________

Cell Phone: __________________ Work Phone: __________________

Emergency Contact Name: ____________________ Relationship: _______________

Home Phone: ________________ Cell Phone: ________________ Work Phone: _____________

E-mail Address: ________________
□ YES □ NO - I would like to receive newsletters and other important information from RCMG via e-mail.

PRIMARY INSURANCE INFORMATION

Ins. Co. Name: ________________________ Policyholder's Name: _____________________
Date of Birth: ________________________ Relationship to Pt: _____________________
Employer: ________________________ Social Sec #: _____________________
ID#: _____________________ Group #: _____________________

Do you have secondary insurance coverage? YES NO (if yes, complete information below)

Ins. Co. Name: _________________________ Policyholder's Name: ____________________
Date of Birth: _________________________
Relationship to Pt: __________________________
Employer:____________________________ Social Sec #: _________________________________
ID#: __________________________________ Group #: ___________________________

RELEASE OF INFORMATION + AUTHORIZATION FOR ASSIGNMENT OF BENEFITS + FINANCIAL POLICY

* I authorize Rush Copley Medical Group to release to my insurance company or its representatives, any information regarding my diagnosis or records of any treatment or examination rendered to me that is required to process my claim for benefits.
* I authorize and request that my insurance company pay directly to Rush- Copley Medical Group the amount due me in pending claims for medical treatments or services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.
* It is understood that, whether I sign as patient or responsible party, I am directly responsible for services rendered which are not paid by insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify Rush-Copley Medical Group in case of any changes in the information contained on this form.
* I authorize Rush Copley Medical Group to release and discuss my financial information with:

Signature:__________________________
My signature acknowledges that I have read and understood the above:

Patient Signature: ____________________ Date: ____________________
Responsible Party (please print): ____________________
Responsible Party Signature: ____________________ Date: ____________________

ACKNOWLEDGEMENT OF RECEIPT

Authorization for Disclosure/Notice of Privacy Practices

Patient Name: DOB:

The above named patient acknowledges receipt of RCMG Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.

The above named patient understands that the practice reserves the right to change the privacy practices that are described in the Notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient.

NOTIFICATION OF HEALTH INFORMATION

Please fill out this form, which will detail how you would like our practice to disclose your personal information. It is the policy of our office to make available to you laboratory results, ultrasound and X-ray reports ordered by your provider by phone or mail. If you have not heard from us in 14 days from the date of your test, please call our office.

_________you may leave personal health information regarding normal test results on my answering machine or voice mail at the following phone number_____________________.

In addition to myself, I authorize the staff to disclose my personal health information as listed below with the following individual:

Name:______________________________ Relationship:__________________________

Home:______________________________Work:________________Cell:______________________

Initial on line next to applicable disclosure:

_________discuss all personal health information, billing information, and pick up sample medications/prescriptions or any written correspondence or referrals on my behalf.

_________discuss all personal health information except

____

*** Person authorized to pick up medication(s) must present a photo ID ***

Signature:____

Date: _______________________

Relationship to patient:____