RUSH

Rush Copley Medical Group

Patient Registration Form

Date: _____

PATIENT INFORMATION

Patient Name: _____
Marital Status : _____
Date of Birth: _____
Social Security #: _____
Employer Name: _____
Employer Address: _____
Email Address _____
I'd like to receive important information about RCMG via email. ( ) Yes ( )No

Gender: _____
Address: _____
City/State/Zip: _____
Home Phone (___)_____
Cell Phone (___)_____
Work Phone (___)_____
Preferred Phone: ( ) Home ( ) Work ( ) Cell
How did you hear about us?_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____
Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone:(___)_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

( ) Same as patient
Responsible Party's Legal Name: _____
Relationship to Patient: _____
Address:_____
City: _____

Gender: ( ) Male ( ) Female
Social Security #: _____
DOB :_____
State: Zipcode:

INSURANCE INFORMATION

Insurance Co. Name :_____
Employer: _____
Policyholder Name: _____
Social Security #: _____

ID#: _____
Group#: _____
Relationship to Patient :_____
Date of Birth :_____

Do you have secondary insurance? ( ) Yes ( ) No
Insurance Co. Name: _____
Employer: _____
Policyholder Name: _____
Relationship to Patient: _____
Social Security #: _____

ID#: _____
Group#: _____
Date of Birth: _____

(DO NOT SCAN)

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name:_____ **DOB**_____

The above named patient acknowledges receipt of Rush Copley Joint Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how Rush Copley Medical Group may use and disclose a patient's protected health information.

AUTHORIZATION REGARDING PROTECTED HEALTH INFORMATION

I authorize Rush Copley Medical Group to leave a voicemail message for me at this **phone number** _____
Name(s) of person(s) that I authorize disclosure of my health/financial information:

☐ None

Name _____ Relationship _____ Phone_____ ( ) Health ( ) Financial

Name _____ Relationship _____ Phone_____( ) Health ( ) Financial

AUTHORIZATION FOR TREATMENT OF A MINOR BY DELEGATED PERSONS

I hereby authorize that the following persons have my permission to seek medical treatment (*) of the above named minor child in my absence and that his/her protected health information (**) may be shared.
Name: _____Relationship to Patient: _____ Phone Number: _____

___ Short-term authorization (30 days- held at reception desk) ___ Long- term authorization (in effect until revoked in writing)

It is my responsibility to notify Rush Copley Medical Group of changes and to complete a new form.

* Medical treatment includes physical exam, routing radiology, and laboratory test, and immunizations.

** Protected health information includes but is not limited to test results, diagnosis, treatment and billing information. Highly confidential information will not be released unless the parent/legal guardian has also completed an Authorization for Release of Confidential Health Information form. This information includes mental illness or developmental disability, psychotherapy notes, HIV, or AIDS testing or treatment (including information regarding test ordering, performance or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

CONSENT FOR TREATMENT/AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

- I consent to examination and treatment that may be required during my office visit. I authorize any emergency care that is deemed necessary by the physician during the visit.
- 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 claims 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 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 the event of any changes in the information contained on this form.

Patient /Authorized Person (Please print) _____

Patient/Authorized Person Signature _____ **Date**_____

Relationship to Patient _____

(SCAN)