Premier Health
Premier Physician Network

Work-Related/Auto/Other Injury:
Use Supplement Info Form

Registration Form

PATIENT INFORMATION:

*Patient Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Sex at Birth: ☐Male ☐Female *Date of Birth: ____/____/____ Aliases/Nicknames: _____

*Street Address/PO Box: _____ *City, State Zip: _____

County: _____ *Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Email Address: _____ Marital Status: ☐Married ☐Widowed ☐Single ☐Divorced

*Occupation: _____ ☐Legally Separated ☐Significant Other

*Employer: _____ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student

*Employer Address: _____ ☐Self Employed ☐Unemployed ☐Active Military

Name of Legal Guardian: _____ Referring Physician: _____

Ethnic Group: _____ Preferred Language: _____ Race: _____ Religion: _____

Special Needs: ☐Hearing ☐Language ☐Speech ☐Vision ☐Multiple Needs ☐No Special Communication Needs ☐Other

Primary Care Physician: _____

EMERGENCY PATIENT CONTACTS:

Name: _____ Phone: (____)_____ Alternate Phone: (____)_____ Relation to Patient: _____

Name: _____ Phone: (____)_____ Alternate Phone: (____)_____ Relation to Patient: _____

RESPONSIBLE PARTY (GUARANTOR): *Check if Same as Patient ☐

*Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Child ☐Other

*Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Street Address/PO Box: _____ *City, State Zip: _____

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)_____ Work Phone: (____)_____

*Employer: _____ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student

*Employer Address: _____ ☐Self Employed ☐Unemployed ☐Active Military

*City, State Zip: _____

ADVANCED DIRECTIVES: (circle if applicable)

Do you have an advanced directive? Living Will: ☐Y / ☐N DNR: ☐Y / ☐N Durable Power of Attorney for health care: ☐Y / ☐N

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐CareFinders ☐Friends/Family ☐Physician ☐Advertisement Other _____

PLEASE COMPLETE INSURANCE INFORMATION ON THE REVERSE SIDE

*Required Field

INSURANCE/POLICY HOLDER INFORMATION (SUBSCRIBER): Please present insurance cards to receptionist

*Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Street Address/PO Box: _____ *City, State Zip: _____

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)_____ Work Phone: (____)_____

*Employer: _____ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: _____

*City, State Zip: _____

*Primary Insurance: _____ *Effective Date: ____/____/____

*Member ID: _____ *Group Number: _____

*Patient Relation to Subscriber: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

*Relationship to Guarantor: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

SECONDARY INSURANCE:

*Name: _____ *SSN: _____
Last First Full Middle 123-45-6789

*Street Address/PO Box: _____ *City, State Zip: _____

*Sex: ☐Male ☐Female *Date of Birth: ____/____/____ *Home Phone: (____)_____ Work Phone: (____)_____

*Employer: _____ *Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Self Employed ☐Unemployed ☐Active Military

*Employer Address: _____

*City, State Zip: _____

*Secondary Insurance: _____ *Effective Date: ____/____/____

*Member ID: _____ *Group Number: _____

*Patient Relation to Subscriber: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

*Relationship to Guarantor: ☐Self ☐Parent ☐Other ☐Spouse ☐Child

Authorization for Treatment and Disclosure of Information for Treatment, Payment, and Operations

AUTHORIZATION FOR TREATMENT
I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Premier Physician Network (PPN). I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS
I consent to PPN using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PPN reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying PPN in writing, except to the extent that Premier Physician Network has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PPN any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT
I realize the bill is my responsibility. I assign and authorize payments be made directly to PPN of all insurance benefits and agree to pay any balance due. I agree, in order for PPN to service my account or to collect any amounts I may owe, PPN may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, and may also contact me by sending text messages or e-mails, using any e-mail address I provide to use which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ _____/_____
Signature of patient or patient's representative Date Date of Birth

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.