PATIENT REGISTRATION

Welcome! As a member of the Tanner Medical Group, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions. Please assist us by providing the following information - a copy of your driver's license and primary and secondary insurance cards. All information is confidential and is released only with your consent.

PATIENT INFORMATION

Patient's Name: _____ Referred by: _____

Date of Birth:_____ Social Security # _____

Race: Caucasian Black Other Sex: Male Female

Marital Status: Married Single Widow Divorced

Patient's Address: _____ Home # _____

_____ Cell # _____

Employer: _____ Work # _____

Spouse's Name: _____

Date of Birth: _____ Social Security # _____

Spouse's Employer: _____ Phone # _____

Employer's Address: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Please list below numbers at which you wish to be contacted regarding future appointments, lab results, etc...

Phone # _____ Phone # _____

RESPONSIBLE PARTY

Name: _____ Relationship: _____ Phone # _____

Address:_____

Primary Insurance: _____ Address:_____

Insured's Name: _____ SS# _____ Group # _____

(Name on the insurance card)

Secondary Insurance: _____ Address:_____

Insured's Name: _____ SS# _____ Group # _____

(Name on the insurance card)

Were you injured on the job? _____If so, have you informed your employer? _____

Do you have other health insurance? _____

TREATMENT OF MINORS

I am the parent/legal guardian of _____, currently a minor, whose date of birth is _____. I authorize **Tanner Medical Group** to provide medical/mental health care to my son/daughter, including but not limited to, diagnostic examinations (including radiology and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures and mental health counseling. I understand that should my child need more invasive diagnostic or surgical procedures, I will be notified prior to such medical care being initiated.

The following individuals have my permission to bring my child to the office for routine medical care.

1. Name: _____ Relationship to patient: _____
2. Name: _____ Relationship to patient: _____
3. Name: _____ Relationship to patient: _____

Date: _____ Parent/Legal Guardian: _____

TANNER HEALTH SYSTEM

OUR POLICY FOR PAYMENTS AND INSURANCE FORMS

1. Our office requires all patients to pay on the day they receive services. We ask this in order to keep down the rising cost of billing.
2. Workers Compensation: If your injury is work-related, we will need to verify coverage and request the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company. Otherwise, you will be responsible for all charges.
3. Non-Covered Services: Any services not covered by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

AUTHORIZATION TO FILE PATIENT'S INSURANCE

☐ I hereby authorize **Tanner Medical Group** to furnish any information required to process this claim. A copy of this authorization shall be as valid as the original. This authorization shall be in effect until revoked in writing.

☐ I authorize and request payment of medical benefits to **Tanner Medical Group**. I also understand that I will be responsible for any charges that are not covered by this assignment.

MEDICARE PATIENT

☐ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related MEDICARE claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to MEDICARE assignment of benefits apply.

TREATMENT AUTHORIZATION

☐ Do you have religious, spiritual or cultural needs or beliefs that would prevent you from receiving medical treatment?
Yes _____ No _____ If yes, please explain _____

☐ I understand that I may be seen by either a physician, physician's assistant, or a nurse practitioner at **Tanner Medical Group**. I hereby authorize **Tanner Medical Group** providers to evaluate and treat my medical needs as appropriate.

SELF PAY

☐ I do not have insurance coverage and would like to apply for financial assistance. Yes _____ No _____

NO SHOW POLICY

☐ This office requires 24 hours notice for appointment cancellations. Missed appointments with no notification of cancellation are considered "no show" appointments. There is a $25 charge for no-shows. Excessive no-shows may result in dismissal from the practice.

PRIVACY NOTIFICATION

☐ I acknowledge that I have received a copy of the Notice of Privacy Practices for Tanner Health System. In receiving this notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

_____ _____
Patient's Signature Date

_____ _____
Parent/ Legal Guardian Date

TANNER HEALTH SYSTEM