PATIENT REGISTRATION

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: _____ Preferred Pharmacy: _____

Date of Birth: _____ Social Security # _____

Race: Caucasian Black Hispanic Other Current Primary Care Doctor: _____

Sex: Male Female Marital Status: Married Single Widow Divorced Preferred Language: _____

Patient's Address: _____ Home#: _____

_____ Work#: _____

Email: _____ Cell#: _____

GUARANTOR/RESPONSIBLE PARTY

Name: _____ Relationship: _____ Phone: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Primary Cardholder's Name: _____

Policy #: _____ Group #: _____

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Secondary Insurance: _____ Primary Cardholder's Name: _____

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Were you injured on the job? Yes No Is this visit a result of a Motor Vehicle Accident? Yes No

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: _____

Date: _____ Parent/Legal Guardian Signature: _____

CONSENT FOR TREATMENT OF ADULTS

I am the legal guardian of _____, whose date of birth is _____. I authorize Tanner Medical Group to provide medical/mental health care to my dependent, 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 dependent need more invasive diagnostic or surgical procedures, I will be notified prior to such medical care being initiated. Please provide copy of Power of Attorney.

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

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

Date:_____ Legal Guardian Signature: _____

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 (initial all that apply)

[ ] 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 understand that payment is due at time of service.

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.

CONTRACT SERVICES

[ ] I understand that there may be a service provided by a third−party contracted person or organization to better facilitate quality care while being treated at any Tanner Medical Group facility or Tanner Hospital. These services include but are not limited to Lab, Radiology, and after−hours call services.

PATIENT PORTAL

[ ] I understand that TMG participates in a secure Health Information Exchange (HIE). The HIE supports integrated system patient care initiative by allowing physicians and healthcare providers to share and access patients health information through an HIE for treatment, payment, and healthcare operations purposes. I understand that I have the right to opt out of having my information available in the HIE by signing an Opt−Out form.

[ ] I understand that as part of the HIE, I have the right to elect to participate in MYTanner Patient Portal to obtain secure access to my personal patient information.

PATIENT IDENTIFICATION NUMBER

In order to better protect your privacy, please choose a 4−digit Patient Identification Number (PIN) to further identify yourself when calling the office or when the specified third parties need to access your personal health information.

YOUR PERSONAL IDENTIFICATION NUMBER (PIN) IS _____

By disclosing the PIN number listed above, the following person(s) may discuss and/or release my protected health information to include: [ ] Test Results [ ] Appointment Information [ ] Rx Requests and Information
[ ] Billing Account Information [ ] Test Preparation Information and Patient Instructions
[ ] Treatment Plan Information

1. Name:_____ DOB: _____ Phone Number:_____

2. Name:_____ DOB: _____ Phone Number: _____

3. Name:_____ DOB: _____ Phone Number:_____

_____ _____
Patient's/Legal Guardian's Signature Date