

**Seton Medical Management
REGISTRATION FORM
WELCOME TO OUR OFFICE**

(Please Print)

Date:		Physician:		
PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	
Street address:		City:	State:	Zip:
P.O. Box:	Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status: Circle	Social Security:
City: Zip:	/ /		S / M / D / W	
Home Phone: ()	Cell Phone: ()	E-mail Address: (Patient or Guarantor)		
Occupation:	Employer:	Work Phone: ()		
Referred to clinic by (please check one box): <input type="checkbox"/> Physician Referral <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family Member				
<input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____				
Name of Spouse, Parent or Guarantor:		Cell Phone: Employer Phone:		
Patient's Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				
Patient Vision Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No		Hearing Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No		
INSURANCE INFORMATION AS PRINTED ON INSURANCE CARD(S)				
Primary Insurance:				
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment:
	/ /			\$
Secondary Insurance:				
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment:
	/ /			\$
EMERGENCY CONTACT				
Name of local relative or friend, not living at same address:		Relationship to Patient:	Work: Home: Cell:	

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or his/her authorized representative, do hereby authorize Seton Medical Management, (SMM) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. SMM is also hereby authorized to release to my physician(s), either as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to SMM. For and in consideration of services rendered. I hereby agree to pay SMM for all charges not covered by insurance payments. I agree to pay all costs of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees not exceeding 33.33% of the unpaid debt, whether suit be necessary or otherwise.

STATEMENT TO PERMIT OF MEDICARE BENEFITS TO PROVIDER PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me on my behalf for any service furnished me by or in SMM, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

MEDICAID PATIENT SIGNATURE

I authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medical fiscal intermediary, the Medical Services Administration and/or parties who may be liable for any of my Medicaid expenses.

AUTHORIZATION TO RELEASE MEDICAL REPORTS(INFORMATION) TO CONSULTING PHYSICIANS

I hereby authorize SMM to release any medical information to physicians other than original referring physicians, who may be involved in my or my child's health care treatment, when requested by these physicians.

By signing this consent, information will be given to requesting physician without further signed authorization.

CONSENT FOR MEDICAL SERVICES

Permission is hereby granted to the authorities of SMM for such medical procedures as may be deemed necessary by my attending physician, or whomsoever he or she may designate.

RESPONSIBILITY FOR PERSONAL PROPERTY

I understand that SMM does not assume RESPONSIBILITY FOR PERSONAL PROPERTY.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of SMM/PHS's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information. Further, I permit a copy of this authorization to be used in place of the original when deemed necessary.

Special Instructions: _____

DATE SIGNATURE OF PATIENT SIGNATURE OF SPOUSE

DATE SIGNATURE OF AUTHORIZED REPRESENTATIVE RELATIONSHIP

DATE WITNESS