REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: ____
(First) (Last)

Date of Birth: ______ /______ /______ (Month) (Day) (Year)   Gender: Male Female

Address: ____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

Home #: ____________________   Cell #: ____________________

E-mail: ____________________   Social Security #: ____________________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other: __________

Contact Method: ☐ Home ☐ Mobile ☐ E-mail   Language: ☐ English ☐ Spanish ☐ Other: __________

EMERGENCY CONTACT

Name: ____________________ Relationship to Patient: ____________________ Phone #: ____________________

PRIMARY INSURANCE

Insurance Name: ____________________

ID #: ____________________

Policy Holder's Name: ____________________

D.O.B: ______ /______ /______ (Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

SECONDARY INSURANCE (If Applicable)

Insurance Name: ____________________

ID #: ____________________

Policy Holder's Name: ____________________

D.O.B: ______ /______ /______ (Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

PHARMACY

Pharmacy Name: ____________________ Phone #: ____________________

Address: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have read a copy of **Suffolk Primary Health LLC** Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's compliance team.

X____

Signature of Patient (or patient's parent or guardian) Print Name Date

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic procedures and medical treatment by **Suffolk Primary Health LLC** as determined necessary in the professional medical judgment of my treating physician, including but not limited to electrocardiograms, blood tests, and administration of medications and vaccinations and obtaining e-script history, as applicable. I am aware that the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantee as to the outcome of any procedures, treatments or examinations have been made to me.

X____

Signature of Patient (or patient's parent or guardian) Print Name Date

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION TO SECOND PARTY

By signing below, I hereby give permission to **Suffolk Primary Health LLC** to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual ________________________ Relationship to patient ______________ Phone #: ____________________

Name of Individual ________________________ Relationship to patient ______________ Phone #: ____________________

X____

Signature of Patient (or patient's parent or guardian) Print Name Date

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-pays, any services that is not covered by your insurance plan, and any service that your insurance company has determined not be "medically necessary".

I have read and understand this information. I understand that my insurance company may deny coverage and request that **Suffolk Primary Health LLC** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services. Without requiring payment at the time of service based on such reliance.

X____

Signature of Patient (or patient's parent or guardian) Print Name Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize insurance payments to be made directly to **Suffolk Primary Health LLC** for services rendered. I understand that I am responsible for any and all balances not covered by my insurance carrier.

I hereby authorize **Suffolk Primary Health LLC** to release medical or incidental information that may be necessary for medical care or processing of insurance claims.

I verify that all information provided regarding my insurance is accurate. I will notify **Suffolk Primary Health LLC** office staff if any changes are made to my insurance. I authorize release of records upon request. A photocopy of these assignments shall be valid as the original.

X____

Signature of Patient (or patient's parent or guardian) Print Name Date