Ooltewah Medical Services
A SkyRidge Health Partner

2013 Patient Registration Form

NAME: _____ MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE:TN, ZIP:_____ HOME PHONE: (____)_____

WORK PHONE: CELL PHONE:_____ E-MAIL ADDRESS: _____

EMPLOYER INFORMATION

PATIENT EMPLOYER: OCCUPATION : _____
EMPLOYER ADDRESS: ,_____

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine?

YES NO Patient Signature: _____

SPOUSE INFORMATION:

NAME: _____ DATE OF BIRTH: _____
EMPLOYER:_____ WORK PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME:_____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS:_____
Street / P.O. BOX / Apt.No City / State / Zip Code

INSURANCE INFORMATION:

WE NEED COPIES OF ALL INSURANCE CARDS IN ORDER TO FILE YOUR CLAIMS

Name of Primary Insurance: Subscriber's Name: _____
(Exact Name As Listed On the Card)

Subscriber's Social Security Number:_____ Date Of Birth:_____
(Required by All Insurance Carriers)

ADDITIONAL INSURANCE:

Name of Secondary Insurance: Subscriber's Name:_____
(Exact Name As Listed On the Card)

Subscriber's Social Security Number:_____ Date of Birth: _____
(Required by All Insurance Carriers)

ADVANCED DIRECTIVES:

It is the right of every adult citizen of Tennessee(18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize CLEVELAND MEDICAL CLINIC INC. to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Ad ministration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize CLEVELAND MEDICAL CLINIC INC. to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.

I grant permission to CLEVELAND MEDICAL CLINIC INC. to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to , testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators,

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Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to CLEVELAND MEDICAL CLINIC INC. for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between CLEVELAND MEDICAL CLINIC INC. and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____

Signature of Patient Date Signature of Responsible Party/Insured

PLEASE COMPLETE THE FOLLOWING IF YOU ARE COVERED UNDER MEDICARE:

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

Are you employed? _____ Date of Retirement _____ Is your spouse employed? _____ Date of Retirement _____

If you or your spouse is employed, please complete the health plan information on the front of this form.

MISCELLANEOUS:

Are you eligible for coverage under the Veteran's Administration? Yes No

Are you eligible for coverage under Worker's Compensation? Yes No

Is your injury/illness due to an automobile accident? Yes No

If yes, please complete the following:

Name and address of auto insurance carrier: _____

Names of Insured: _____ Policy or ID#: _____

Accident Date: _____ Accident Location: _____

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME or Legal Guardian: _____ DOB: _____ SSN: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER: _____

ADDRESS: _____

FATHER'S NAME or Legal Guardian:: _____ DOB: _____ SSN: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER: _____

ADDRESS: _____

I hereby authorize, Behavioral Health of Ooltewah, its physicians and staff, to render appropriate medical care to my dependent listed under patient information on the front of this form.

_____ _____

Signature of Responsible Party Date

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.
I AGREE TO NOTIFY IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

Signature: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____