

Metropolis Medical

2010 Registration/Consent Form

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Please read and complete the following information to the front desk with your identification and insurance card(s). If you have any question concerning billing or insurance coverage, please ask to speak with the office manger.

PERSONAL INFORMATION

Last Name:		First Name:		MI:	Sex	Age:
Driver's Lic. #/ State		SSN:	Email Address:			
Home Address: Street / City / State / Zip				Primary Tel.		Type
Mailing Address (if different): Street / City / State / Zip				Secondary Tel.		Type
Emergency Contact:		Relationship:		Tel:		

INSURANCE INFORMATION

Referring Physician/Person:		Phone:	
Primary Care Physician (if any):			
Primary Insurance:	ID #	Tel.:	
Secondary Insurance (if any):	ID#	Tel:	
Pharmacy Address:	Phone	Fax	
Occupation:	Employer:	Tel.:	

HIPAA PATIENT CONSENT

Our Notice of Privacy Practices, "Notice", provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy from our office. You have the right to request that we restrict how PHI about you is used or disclose for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing below, you consent to our use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent if it is done so in writing, signed by you, and delivered to our office. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice is providing this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Practice may condition receipt of treatment upon the execution of this consent form. The patient understands that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosure will then cease.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Metropolis Medical for services rendered. I understand that I am financially responsible for my office visit co-payment at the time of the visit as well as vaccinations and injections. I also understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. Late payments are assessed at 2% per month after the first 60 days. Appointments require a 24 hour cancellation notice or a \$50.00 "No-Show Fee" MAY be applied. Also reminder calls are performed as a courtesy and are not required to a confirm appointments.

LABORATORY CONSENT INFORMATION

To provide you with effective medical care, certain lab work may be ordered on a routine basis. Lab specimens collected in our office may be sent to an outside laboratory for analysis and will be billed separately from your office visit. We will attempt to see that the laboratory has your correct insurance information. By signing this consent you are giving us permission to send your lab work out when necessary and you agree to be financially responsible for any charges not covered under your insurance contract

X	X
Patient Signature & Date	Practice Representative Signature & Date
X	
Patient Representative Signature & Date	Printed Name & Relationship to Patient