

**TMH PHYSICIAN PARTNERS
PATIENT REGISTRATION FORM**

PATIENT INFORMATION

Patient Full Name: _____ Patient prefers to be called: _____
Date of Birth: _____ Social Security #: _____ - _____ - _____ Sex: Male Female
Mailing Address: _____ Apt/Unit#: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
Marital Status: Single Married Divorced Widowed Separated Email: _____
Referring Physician: _____ Primary Care Physician: _____

Patient's Employer Name: _____
Employment: Full-time Part-time Not working Self Emp Retired Military Student: Full-time Part-time N/A

Emergency Contact Name: _____ Relationship to Patient: _____
Emergency Contact Phone: (____) _____ Emergency Contact Other Phone: (____) _____

FOR CHILDREN - guarantor information/responsible for payment:

Guarantor Name: _____ Guarantor Relationship: _____
Guarantor Date of Birth: _____ Guarantor Address: _____ Apt/Unit#: _____
City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION- PRIMARY PLAN -POLICY INFORMATION

Insurance Company: _____ Subscriber name: _____
Cert/Policy #: _____ Group Name: _____
Group#: _____ Policy Telephone #: _____
Relationship to the insured: Self Spouse Child Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: _____ Zip: _____
Policy Holder Date of Birth: _____ Policy Holder Sex: Male Female

INSURANCE INFORMATION - SECONDARY PLAN - POLICY INFORMATION

Insurance Company: _____ Subscriber name: _____
Cert/Policy #: _____ Group Name: _____
Group#: _____ Policy Telephone #: _____
Relationship to the insured: Self Spouse Child Other

If you are not the policy holder, please complete the following:

Policy Holder Name: _____ Address: _____ City: _____ ST: _____ Zip: _____
Policy Holder Date of Birth: _____ Policy Holder Sex: Male Female

EDUCATION: We want to provide education regarding your health conditions and would like to know the following:

My Preferred teaching method is: I have no preference Written education materials Demonstration

Barriers to learning: Language barrier Poor eyesight Poor Hearing Other _____
 No barriers

Would you like someone with you during any education? (Name) _____ (Relationship) _____

Primary Language: English Spanish Other: _____

Race: Asian African American American Indian Caucasian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other: _____

Contact Preference: Phone Email Both Phone/Email

TMH PHYSICIAN PARTNERS ASSIGNMENTS and AUTHORIZATIONS

CONSENT TO TREATMENT: I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of local anesthetics and/or blocks, and any and all medications and technical procedures which in the judgment of the Healthcare Provider attending and consulting may be considered necessary and advisable to treat while I am a patient of a provider in the employment of TMH Physician Partners. I understand that an additional Informed Consent would be obtained from me after a full explanation before any type of Surgery or Invasive procedure would be done. In addition, I consent to the appropriate disposal by TMH Physician Partners of any specimens or other bodily materials removed during technical procedures or for testing purposes. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made as to the results of any therapies and or procedure(s).

PATIENT'S VALUABLES: TMH Physician Partners does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby certify that the information provided by me in order to apply for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to Tallahassee Memorial Healthcare and its TMH Physician Partners of all benefits due me under the terms of said policies and programs. I assign payment to the provider(s) rendering medical services and the provider(s) for whom the organization is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance/copayments or any other charges incurred which are not paid by my insurance or other third-party payors together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RELEASE OF INFORMATION: I understand that my healthcare information will be exchanged among my health care providers through a Health Information Exchange (HIE). TMH will follow state and federal laws, including HIPAA, when protecting the release of sensitive information, which includes but is not limited to behavioral health, drug/alcohol/substance abuse, abuse treatment, sexual abuse, genetics testing, HIV/STD and adoption records. Participating in the HIE is not a condition to receive health care, and I may opt-out (decline) participating in the exchange. I also authorize Tallahassee Memorial Healthcare and its TMH Physician Partners and any provider examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis, or persons or entities such as regulatory agencies or quality organizations.

CONSENT TO CONTACT: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from TMH and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services provided by Tallahassee Memorial Healthcare and its TMH Physician Partners.

HMO ELIGIBILITY GUARANTEE: I hereby certify that if I am enrolled in an HMO and/or Medicaid HMO that I am receiving healthcare services through the Primary Care Physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a statement/bill from Tallahassee Memorial Healthcare and its TMH Physician Partners.

PRIVACY NOTIFICATION: I have received notice of the Tallahassee Memorial Healthcare [Notice of Privacy Practices](#) and understand that I may obtain a copy of this notice upon request.

My signature below represents that I have read the above and thereby give my agreement and authorization to all of the above.

_____	_____	
Printed Patient Name	Date of Birth	
_____	_____	_____/_____/_____
Patient Signature or Patient Representative	Relationship to Patient (if signing on their behalf)	Date / Time

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION Date(s) of Service Requested: ___/___/___ to ___/___/___	NAME: _____ DATE OF BIRTH: ___/___/___ LAST 4 NUMBERS OF SSN: _____ DAY PHONE: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____		
RELEASING PARTY <i>(Who has the information you want released?)</i>	NAME: _____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP CODE: _____ FAX NUMBER: _____ (URGENT CARE PATIENT ONLY)		
RECEIVING PARTY <i>(Where do you want the information sent? Who may have the information?)</i>	NAME: _____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP CODE: _____ FAX NUMBER: _____ (URGENT CARE PATIENT ONLY)		
HOSPITAL (check all that apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Cardiac Reports/ EKG <input type="checkbox"/> History and Physical <input type="checkbox"/> Other _____ <input type="checkbox"/> Consultation Reports _____ <input type="checkbox"/> Operative Reports _____ <input type="checkbox"/> Laboratory Reports _____ <input type="checkbox"/> Radiology Reports/ X-Ray Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Entire Record (not including psychotherapy notes)		OFFICE/CLINIC (check all that apply): <input type="checkbox"/> Office Visits <input type="checkbox"/> Immunizations <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record (not including psychotherapy notes)	
BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Assessments <input type="checkbox"/> Progress Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Medications <input type="checkbox"/> Entire Record (not including psychotherapy notes)			
FORMAT: <input type="checkbox"/> USB/ CD <input type="checkbox"/> Paper <input type="checkbox"/> Other _____		DELIVERY METHOD: <input type="checkbox"/> Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted	
<p>PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at anytime. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above; 2) Any cancellation will apply only to information not yet released by facility or practice; 3) Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; 4) Refusing to sign this form will not prevent my ability to get treatment; 5) TMH will not share or use my health information without my permission other than by ways listed in TMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; 6) A fee may be charged for providing the protected health information; 7) I have a right to receive a copy of this form upon my request.</p>			
<p>I DO NOT WANT TO RELEASE (check all that apply): <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> GENETIC INFORMATION <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE (STD) <input type="checkbox"/> DRUG/ALCOHOL <input type="checkbox"/> MENTAL HEALTH</p>			
<p>This permission expires one year after the date of my signature unless another date or event is written here: _____</p>			
<p>Signature: _____ Print Name: _____ Date: _____</p>			
<p>Witness Signature: _____ Print Name: _____ Date: _____</p>			
<p>Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral/ mental health without parental consent, the minor must sign this authorization.</p>			
<p>Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form. Check the box below to indicate the relationship/ authority (Written Proof May be Requested):</p>			
<input type="checkbox"/> Healthcare Agent/ POA <input type="checkbox"/> Guardian <input type="checkbox"/> Executor/Administrator/Attorney in Fact <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Adult Child <input type="checkbox"/> Affidavit Next of Kin <input type="checkbox"/> Other _____			

**TMH PHYSICIAN PARTNERS
Verbal Communication Authorization**

I, _____ DOB _____, authorize Tallahassee Memorial Physician Partners to **verbally disclose protected health information contained in my medical and billing records** to the individual(s) indicated below. I understand that the purpose of this disclosure is to facilitate communication regarding my medical care. I further understand that this does not authorize release of medical record copies, which requires a separate written authorization by me.

_____ **I specifically authorize the release of any and all medical information, including that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.**

Initials

Date/Time

Special Instructions or Restrictions on Disclosure:

You **may** _____ or **may not** _____ leave messages on my home _____, work _____, cell phone _____ voice mail.

Other: _____

The information indicated above may be released to:

Name: _____

Relationship: _____

Phone number: _____

I understand that I have the right to revoke this authorization, except to the extent that Tallahassee Memorial Physician Partners-_____ has already taken action based on it. I also understand that when my health information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of the information identified on this authorization is voluntary and I need not sign this form to ensure health care treatment.

Signature of Patient or Patient's Representative

Witness

Relationship to Patient (*attach documentation of guardianship or
Power of Attorney if applicable*)

Date/Time witnessed

Date/Time signed

REVOCATION OF AUTHORIZATION: I hereby revoke the previous authorization allowing disclosure of my protected health information to the above-named individual.

Signature of Patient or Patient's Representative

Date/Time

Tallahassee Memorial Healthcare

Ambulatory Care Services

To Our Patients:

Under the Patient Self-Determination Act it is your right under law to accept or refuse medical care. Advance Directives can protect this right if you ever become mentally or physically unable to choose or communicate your wishes due to an accident or an illness.

An Advance Directive is any instruction you give relating to the provision of healthcare in the event you become unable to make your own decisions. Examples of Advance Directives include: Living Will; Durable Power of Attorney; Appointment of a Healthcare Surrogate. When using Advance Directives, you protect your right to make medical choices that can affect your life; your family can avoid the responsibility and stress of making difficult decisions; and your physicians will have guidelines for providing your care.

Living Wills are written instructions that explain your wishes regarding healthcare should you have a terminal condition such as cancer, Alzheimer's disease, etc. They are called Living Wills because they take effect while the patient is still alive.

A Durable Power of Attorney for Healthcare allows you to name a person (called a surrogate/proxy) to make decisions for you if you become unable to do so. Also, in the Power of Attorney, you may list the healthcare decision that you desire concerning life-prolonging care, treatment, services and procedures, as well as special provisions and limitations. These life-prolonging measures may include cardiopulmonary resuscitation, intravenous therapy, feeding tubes, respirators, dialysis, pain relief, Do Not Resuscitate orders, and organ donation.

A Healthcare Surrogate (proxy) is a person you choose to make healthcare decisions for you if you are not able to do so for yourself. This person should be someone who knows your wishes and who will make decisions on what he/she believes you would want.

Once you have completed your Advance Directive, please discuss the details of the directive with your physician, family members, minister, surrogate and/or close friends. Make sure your surrogate has a copy of your Advance Directives, place a copy in the glove compartment of your car and give copies to those whom you feel should know.

If an emergency takes place in our office your Advance Directive would not immediately be honored because it is not possible in an emergency situation to determine your chance of survival or recovery. We would call 911 and begin our emergency procedures unless a physician is present who knows your medical history and Advanced Directive, and gives the order to stop. Otherwise, once you have reached the ER or hospital where a better determination of your condition can be made, your Advance Directive will be honored if you are not able to express your wishes.

If you need help in preparing Advance Directives or if you would like more information you may contact a lawyer, your State Attorney General's office, Hospitals, Hospices and Long-Term Care Facilities. You may also seek information and assistance from the Risk Management Department at Tallahassee Memorial HealthCare by calling (850) 431-5364.