Brockport ASAP Medical Care
Registration Form

Patient Name:_____ **Date of Birth**:_____
Address:_____
_____

Home Phone:_____**Cell Phone**:_____ **Gender**(Circle One): **M / F**

Insurance Co-Pay or Deductible:_____

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, X-Rays, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to Brockport ASAP Medical Care for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I also understand that I must pay in full today for all services rendered. I also understand that if my insurance is accepted, *I must pay all applicable insurance copays and deductibles today*. If my insurance cannot be verified at time of service, I will pay for all services in full.

Release of Records: I authorize Brockport ASAP Medical Care to release (verbal or in writing) confidential medical information to any person or entity in order to better provide evaluation and treatment and ensure payment. I understand that this may include my insurance carrier, employer(if treatment is related to employment) or other health care operations which may be liable to me or my practitioner(s) for charges for treatment. My information may also be used for quality management, utilization review, transfer, and follow up purposes.

Patient/Guardian Signature:_____ Date:_____

HIPAA

The Health Insurance Portability & Accountibility Act (HIPAA) is a federal program that requires all medical records and other indiviual identificable health information used or disclosed by us, whether electronically, on paper, or orally, are kept confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

I authorize the release of information including, but not limited to, the diagnosis, records, examination rendered to me and claims information.
This information may also be released to:

[ ] Self Only [ ] Spouse [ ] **Primary Care Physician_____** [ ]Other_____

Patient/Guardian Signature:_____ Date:_____

Consent to Treat Minor Children

I,_____(Parent/Guardian) of_____(Child's Name), do hereby consent to any medical care, x-rays, and administration of anesthesia, determined by a physician to be necessary for the welcare of my child while said child is under the care of Dr._____.

Parent/Guardian Signature:_____ Date:_____