

**Patient Information**

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  Mr.  Mrs.  Miss  Other \_\_\_\_\_

Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

May we leave a message about appointments or normal test results on the phone numbers you provided?  Yes  No

Would you like to receive appointment reminders via text message on your cell phone?  Yes  No

*You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.*

Marital Status:  Married  Single  Separated  Divorced  Widowed  Partner  Unknown

Ethnicity:  Hispanic/Latino  Not Hispanic/Latino  Other \_\_\_\_\_

Race:  Caucasian  African American  Asian  Other \_\_\_\_\_

Birth Sex:  Male  Female

Gender Identity:  Male  Female  Female-to-Male  Male-to-Female  Genderqueer  Choose not to disclose  Other

Transgender:  Yes  No

Sexual Orientation:  Lesbian  Gay/homosexual  Straight/heterosexual  Bi-sexual  Choose not to disclose  Other

Primary Language:  English  Spanish  French  Other: \_\_\_\_\_

Student Status:  N/A  Full-time  Part-time

Employment Status:  N/A  Full-time  Part-time Employer: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

*Alternate Contact: If you want us to contact you at an alternate address or telephone number, please provide below:*

Alt. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Person Financially Responsible For Payment (Guarantor) if different from patient**

Last Name: \_\_\_\_\_  Mr.  Mrs.  Miss  Other: \_\_\_\_\_ Sex:  Male  Female

First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Middle: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Financially Responsible Person's Email Address: \_\_\_\_\_

**Primary Insurance**

**Secondary Insurance**

Insurance Company: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Member or Policyholder ID #: \_\_\_\_\_

Member or Policyholder ID #: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release**

**CONSENT FOR TREATMENT:** I consent and authorize a Roper St. Francis Physician Partners (“RSFPP”) physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

**PAYMENT GUARANTEE:** I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian’s responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

**This consent is valid for one year from date signed.**

Print Patient’s Name: \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Print Legal Guardian’s Name: \_\_\_\_\_

Legal Guardian’s Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Ongoing Communication Regarding Your Healthcare**

**ONGOING COMMUNICATION: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, WHOM?**

By listing an individual and/or entity below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual and/or entity you have listed. You may list specific date range or event.

Beginning date/event to be released: \_\_\_\_\_ End date/event to be released: \_\_\_\_\_ Or all healthcare information \_\_\_\_\_

Authorized Individual or Entity	Phone Number	Relationship	Address
_____	_____	_____	_____
_____	_____	_____	_____

\*Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above.

**Authorization is not required for treatment purposes.**

To request restrictions of the use of your information, you must complete a separate **Request to Restrictions Form**.

**Prescriptions**

For your convenience, please list below the individual(s) that you authorize to receive prescriptions from your RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____