ROPER ST. FRANCIS PHYSICIAN PARTNERS

PATIENT INFORMATION FORM

Referred by: _____ **Primary Care Physician**: _____

Last Name: _____ **First Name:** _____ **Prefix** □ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Middle Name: _____ **Preferred Name:** _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **SSN:** _____ - _____ - _____

Address: _____ **City:** _____**County:** _____ **State:** _____ **Zip:** _____

Email: _____ **Home:** ( )_____-_____ **Cell:** ( )_____-_____**Work:** ( )_____-_____

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.

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**: ( )_____-_____

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed □ Partner □ Unknown

Ethnicity: □ Not Hispanic / Latino □ Hispanic / Latino □ Declined to Specify

Race: □ White □ Black / African American □ Asian □ American Indian / Alaska Native □ Native Hawaiian / Other Pacific Islander □ Declined to Specify □ Other Race

Birth Sex: □ Male □ Female **Gender Identity (optional):** _____

Sexual Orientation (optional): □ Straight/heterosexual □ Lesbian □ Gay/homosexual □ 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:** _____

Name of Pharmacy: _____ **Address**: _____ Phone: ( ) _____-_____

E**mergency Contact Name**: _____ **Relationship**: _____ Phone: ( ) _____-_____

Guarantor/ Person Financially Responsible For the Payment If Other Than The 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: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Email Address of Guarantor/ Person Financially Responsible: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

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

CONSENT FOR TREATMENT: I consent and authorize 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 for treatment, authorization, assignments of benefits and referral release 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(S) WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO 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.

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

Date Range or event of information to be released, select one:
Beginning Date / Event to be Released: _____ End Date / Event to be Released: _____ Or All Healthcare Information _____

*****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 and disclosure of your information, you must complete a separate **Request to Restrictions Form.**

Prescriptions

For your convenience, please specify any individuals you authorize to pick up your prescriptions from RSFPP provider(s).

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