MOUNTAINSTAR
Millcreek Primary Care
affiliated with St. Mark's Hospital

Patient Registration Form

PATIENT INFORMATION (Please Print)

Patient's Name Last _____ First _____ Middle _____

Address _____ Apt._____

City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email Address _____

Date of Birth MM _____ / DD _____ / YY _____ **Sex** ☐ Female ☐ Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____ - _____ - _____ Employer Name _____

How did you hear about us? ☐ Existing Patient ☐ Marketing ☐ Google ☐ Recommended from family/friend
☐ Recommended from Provider (Name)_____ ☐ Insurance ☐ Other _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name Last _____ First _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Check here if information is same as Patient Information ☐

Responsible Party Name Last _____ First _____

Date of Birth MM _____ / DD _____ / YY _____ **Sex** ☐ Female ☐ Male ☐ Transgender

Address _____ Apt._____

City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Social Security Number _____ - _____ - _____ Employer Name _____

Email Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Patient (or Responsible Party) Signature _____ ***Date*** _____

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Patient Consent Form

Consent to Medical Services

I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood-borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), a physician orders such tests diagnostic purposes.

Assignment of Benefits

This assignment of benefits allows the healthcare facility and/or facility-based physicians to be paid directly by my health insurance carrier or other health benefit plan for the laboratory services, the healthcare facility and/or facility-based physicians provide to me. In return for the services rendered and to be rendered by the facility and/or facility based physicians provided to me. In return for the services rendered and to be rendered by the facility and/or facility-based physicians all right, title, and interest in all benefits payable for the laboratory services rendered, which are provided in any and all insurance policies and health benefit plans form which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the healthcare facility and/or facility-based physicians an independent right of recovery against my insurer or physicians to pursue any such right or recovery. In no event will the healthcare facility and/or facility based physicians retain benefits in excess of the amount owed to the healthcare facility and/or facility-based physicians for the care and treatment rendered during my visit(s).

Payment Agreement The patient/responsible party or legal guardian obligates himself to the payment of practices account incurred in accordance with the regular rates and terms of the practice at time of discharge. If the patient/responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

Medicare Patient Certification I certify that the information given by me in applying the payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf.

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any Laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the healthcare facility and/or facility-based physicians.

X_____

Patient/Parent/Guardian/Conservator Signature Relationship to Patient Date

X_____

Print Patient Name

X_____

Witness Signature Print Name Date