Emmanuel Christian Health Center Patient Registration Form rev 7/16

EMMANUEL CHRISTIAN HEALTH CENTER, P.A.
918 Rolling Acres Road Suite 1, Lady Lake, FL 32159 (352) 259-1991

Today's Date _____ **WELCOME! IT IS OUR PRIVILEGE TO SERVE YOU.**

1 Patient Personal Information

First Name: _____**Middle Initial:** ____ **Last Name:** _____ Jr./Sr._____

Title: Mr. _____ Mrs. ____ Ms.____ Miss_____ Dr._____ Marital Status: (S) _____ (M) _____ (W)_____ (D) _____

Age: _____Date of Birth: ____/_____/_____ Social Security #: _____

Male _____ Female _____ Student _____ If Student, name of School: _____

Race: White _____ African American _____ Asian _____ American Indian _____ Hispanic _____ Other _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino_____

Local Mailing Address: _____

City, State, Zip code: _____

Permanent/Street Address: _____

City, State, Zip code: _____

Email address (if you have one): _____

Name of Spouse: _____Spouse Date of Birth _____

Name of Employer: _____ Spouse's Employer: _____

Who referred you? _____ Physician _____ Friend _____ Relative _____Self _____

2 Telephone/ Patient Portal Access/ Release of Personal Information

We now offer a secure online patient portal for you to view your health records and messages from our office at www.YourHealthFile.com. Ask our office staff to assign you a user name and password to access your portal. A computer and an Internet connection are required.

Home Phone: _____ Mobile_____ Work Phone _____

I prefer to receive calls at: Home ____ Work ____ Mobile _____ Best time of day to reach me: Time_____ Day/s _____

I give my permission to _____ Leave a message on my answering machine at home.

_____ Leave a message at my place of employment

_____ Discuss my medical condition, lab results or financial information with the following person/s

Name/s and Relationship _____ Phone#: _____

In case of EMERGENCY, please give name of nearest friend or relative you wish to have contacted.

Name _____ Phone#:_____

Name _____ Phone#: _____

3 Medicare Beneficiaries Only

I hereby assign all Medicare benefits to which I am entitled to Vivian J. Woodard, M.D. and Emmanuel Christian Health Center. I understand that Medicare assignment pays 80% of the allowable charge and that I will be responsible for the annual deductible charge and as well as the 20% that Medicare does not pay of the allowable. I further agree to personally pay the cost of all services I receive which are not covered by Medicare, such as deductibles, co-payments, and any non-covered services. I request that payment of authorized Medigap benefits be made on my behalf to Emmanuel Christian Health Center for any services furnished me by Vivian J. Woodard, M.D. or her associates.

Signature _____ Date_____

4 Health Insurance Information

Please attach a copy of your insurance cards and driver's license or photo ID with this completed form.

5 Payment Policy **Please read Carefully!**

WE ACCEPT CASH OR CHECK ONLY. WE ARE UNABLE TO ACCEPT OR PROCESS CREDIT/DEBIT CARDS.

For HMO, PPO, Medicare or other managed care patients: You will be responsible for paying any deductibles, coinsurance, copays, and charges for any non-covered services. **Payment is expected at the time service is rendered and is payable by cash or check only!**
For Patients with No Insurance or with HSA cards: Full payment is expected at the time of service by cash or check. **If you need assistance obtaining reimbursement from your HSA card contact your insurer.**

Ultimately you are responsible for any covered charges that your insurance does not pay or that are not covered by your insurance. If your account requires action by our collection agency, any collection costs will be added to your balance.

6 Authorization, Release & Confidentiality

My signature below authorizes any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or any carrier, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to be paid to Emmanuel Christian Health Center, P.A.

Our Notice of Privacy Practice (NPP) provides information about how we may use and disclose protected health information (PHI) about you. It discusses your rights as a patient and Emmanuel Christian Health Center's duties with respect to your PHI. You have the right to review our policy before signing this acknowledgement. If we change our Notice you may obtain a revised copy by contacting our office.

Further, my signature indicates that I understand and accept the financial policy described above. All therapeutic communications, records, and contacts with Emmanuel Christian Health Center, P.A. will be held in strict confidence in accordance with Health Insurance Portability & Accountability Act (HIPAA). I can request my medical records in writing via mail or FAX. I also give permission to access my prescription history information electronically provided by my pharmacy or insurance company.

_____ _____

**********Signature of patient or Legal Guardian********** Date

Did you remember to sign this form?!