HUTCHINSON CLINIC, PA

PATIENT REGISTRATION

Account: _____ Patient DOB: _____
Patient Name: _____ Patient SSN: _____
Street: _____
City: _____ State: _____
Zip Code: _____ Patient Number: _____

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY

Guarantor Name: _____ Cell: _____
Guarantor Address: _____ Employer: _____
Guarantor City: _____ Date of Birth: _____
Guarantor State: _____ Guarantor Zip: _____ Sex: _____
Home: _____ SSN: _____
Work: _____

PRIMARY INSURANCE
Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Certificate: _____ Suffix: _____
Group: _____ Number: _____

SECONDARY INSURANCE
Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Certificate: _____ Suffix: _____
Group: _____ Number: _____

Authorization to Release Information: I authorize Hutchinson Clinic, P.A. to release any medical information that may be necessary for either medical care or for processing of insurance benefits. This includes the release of information to the Hutchinson Clinic specialty physicians for Rural Health Clinic.

Assignment of Insurance Benefits: I authorize direct payment to Hutchinson Clinic, P.A. It is my responsibility to understand the extent of coverage and limitations of insurance policy, including referral and pre-certification requirements. I am financially responsible for services not covered by insurance. I understand that delinquent accounts are subject to collection activity including access to credit reports and referral to a collection agency.

Consent For Treatment: I authorize treatment preformed or prescribed by a physician/provider and understand that no guarantee is made as a result of examination or treatment.

One Time Authorization: I request payment of authorized Medicare/Medigap/Medicaid benefits to Hutchinson Clinic, PA. I authorize release of medical information necessary for processing insurance benefits to Centers of Medicare and Medicaid and other insurance agents.

I have read and understand the above consent for treatment, financial responsibility, release of information and insurance authorization.

_____ _____
Signature of Patient, Parent or Guardian Date