GAINESVILLE FAMILY PHYSICIANS
NORTH FLORIDA REGIONAL HEALTHCARE

PATIENT REGISTRATION FORM

Last name:	First name:	Middle Initial:	Pt #:
Mailing address:		Age:	Gender:
City, State, Zip:		Date of Birth:	
Physical address (if different from mailing address):		Cell #:	
Name of Physician or Contact that referred you:		Home #:	
Employer or School:		Work #:	
Employment status: ☐Full Time ☐ Part Time ☐Retired ☐Student ☐Disabled ☐Unemployed		Email:	
SSN #:	Language: ☐English ☐Spanish ☐Other	Marital:	
Race: ☐Caucasian ☐Black ☐Hispanic ☐ ____________________________		Ethnicity: ☐Latino/Hispanic ☐Other ☐Refused	
Do you have a living will? ☐ Yes ☐ No		If yes, copy provider: ☐ Yes ☐ No	
Preferred Pharmacy:		Pharmacy Location:	

Emergency Contact Information

Emergency Contact Name:	
Emergency Contact Phone:	Relationship to Contact:

Patient Contact Information

I wish to be contacted in the following manner: (Check all that apply)

Home phone: ☐# ___________	Work phone: ☐# ___________	Mobile phone: ☐# ___________	Web portal: ☐# ___________

Patient Authorization / Disclosure

☐ I consent to office leaving message with detailed information

☐ I consent to office leaving message with call back # only

☐ I consent to office faxing to this fax number: (______) _________-__________

Consent to release protected health information (PHI) to the following person(s):

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Primary Insurance

Insurance Company Name:	Group #:
Subscriber name:	Claims Mailing Address (back of card):
Member #/Policy #:	Subscriber Employer Name:
Subscriber Date of Birth:	Subscriber Relationship to Patient:

Secondary Insurance

Insurance Company Name:	Group #:
Subscriber name:	Claims Mailing Address (back of card):
Member #/Policy #:	Subscriber Employer Name:
Subscriber Date of Birth:	Subscriber Relationship to Patient:

How did you hear about us? ☐ Family ☐ Friend ☐ Doctor ☐ Phone Book ☐ Billboard/Sign ☐ Internet ☐ Health Fair ☐ Other

I understand and agree: I authorize treatment and will be responsible for the payment of all charges incurred on behalf of myself or family member. I authorize payment of medical benefits to: Gainesville Family Physicians, LLC

Signature: ____ Date: ______________________

GAINESVILLE FAMILY PHYSICIANS
NORTH FLORIDA REGIONAL HEALTHCARE

PATIENT FINANCIAL AGREEMENT

PATIENT NAME_______________________________________DATE OF BIRTH_______________

1. _______________(Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, GAINESVILLE FAMILY PHYSICIANS may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. ______________(Patient or Guardian Initials)

Third Party Collection. I acknowledge that GAINESVILLE FAMILY PHYSICIANS may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ______________(Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to GAINESVILLE FAMILY PHYSICIANS any insurance or other third-party benefits available for health care services provided to me. I understand GAINESVILLE FAMILY PHYSICIANS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GAINESVILLE FAMILY PHYSICIANS, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. __________________(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to GAINESVILLE FAMILY PHYSICIANS by the Medicare or Medicaid program.

5. __________________(Patient or Guardian Initials)

When applicable, for children of divorced parents, I understand that payment is due at the time of service regardless of who is responsible by order of the divorce decree.

PATIENT FINANCIAL AGREEMENT

GAINESVILLE FAMILY PHYSICIANS
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6. ________________(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for GAINESVILLE FAMILY PHYSICIANS, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that GAINESVILLE FAMILY PHYSICIANS or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or GAINESVILLE FAMILY PHYSICIANS or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

7. ________________(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

8. ________________(Patient or Guardian Initials)

Cancellation, No Show and Late to Appointment Policy

- I understand that GAINESVILLE FAMILY PHYSICIANS reserves the right to reschedule my appointment if I arrive late to my schedule appointment by 15 minutes or more.
- I understand if I miss two or more consecutive appointments without a 24-**hour'**s advance notice GAINESVIILE FAMILY PHYSICIANS reserves the right to discharge me from the practice.

____ __________________

PRINT Name of Patient or Patient Representative Date

____ __________________

Signature of Patient or Patient Representative Date

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify) ______________________________

GAINESVILLE FAMILY PHYSICIANS
NORTH FLORIDA REGIONAL HEALTHCARE

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Medicare or Blue Cross Blue Shield of Florida) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID – Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration, Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

____ ____________________

Signature of Patient or Personal Representative **Date**

____

Print Patient's Name

GAINESVILLE FAMILY PHYSICIANS
NORTH FLORIDA REGIONAL HEALTHCARE

General Consent for Care and Treatment Consent

Patient Name: ____ **Date of Birth:**______________

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ _____________________________
Signature of Patient or Personal Representative **Date**

____ _____________________________
Printed Name of Patient or Personal Representative **Relationship to Patient**

____ _____________________________
Printed Name of Witness Employee Job Title

____ _____________________________
Signature of Witness **Date**