Modern Care Medical Group, LLC
FAMILY PRACTICE
Directing the focus back to the Patient

PATIENT REGISTRATION FORM (Page 1)

It is our pleasure to welcome you to Modern Care Medical Group Family Practice and we look forward to serving you as your Primary Care Provider. Please fill out the following registration information including as much detail as possible. Please do not hesitate to ask our staff for assistance.

Provider: ☐ **Dr. Los**

Social Security # _____ - ____ - _____ Date of Birth ____ / ____ / _____ ☐ Male ☐ Female

Last Name: _____ Middle: _____ First: _____

Street Address: _____ Apt/Suite _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Preferred: ☐ Home ☐ Cell

Email: _____ Preferred reminder method: ☐ Phone ☐ Email

Occupation: _____ **Employer:** _____

Martial Status: ☐ Single ☐ Married

Spouse's Last Name: _____ Middle: _____ First: _____

Work Phone #: _____ Cell #: _____

If you have Medicare, are you or your spouse currently working? ☐ **Yes** ☐ **No**

<u>Insurance Details</u> (A copy of your Insurance Card will be kept on file – please advise if changes)

Primary Insurance information: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of insurance: _____ **Policy #:** _____

Secondary Insurance information: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of insurance: _____ Policy #: _____

<u>Emergency Contact</u>:

Last Name: _____ Middle Initial: _____ First: _____

Phone #: _____ Relationship: _____

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PATIENT REGISTRATION FORM (Page 2)

It is the policy of Modern Care Medical Group to communicate only with the patient using contact information provided by the patient. HIPAA of 1996 establishes the right for patients to request alternative methods of communication from our office.

If there is anyone other then yourself that you would like Modern Care Medical Group to release information to, please list them below. Please check the information that you authorize them to receive.

Name: _____ ☐ Medical Info. ☐ Billing Info.

Phone #: _____ Relationship: _____

If this request changes, you are responsible to contact Modern Care Medical Group of any change.

Receipt Acknowledgement of Notice of Information Privacy Procedures

I (Patient's Name) _____ have received a copy of Modern Care

Medical Group's Notice of Information Privacy Practices.

Signature of Patient: _____ **Date**: _____

Consent for Treatment & Acknowledgment of Patient Billing Responsibilities

I/we hereby authorize Modern Care Medical Group (MCMG) to administer diagnostic, medical procedures, and treatments as may be necessary for proper health care.
I authorize release of any medical information in possession of MCMG to any consultant medical personnel for the purpose of rendering treatment to myself to continue my care.
All professional services rendered are the responsibility of the patient. MCMG will file your insurance at time of service however, if your insurance requires you to pay a deductible or co-insurance, you are responsible to pay these costs at time of service.

I hereby authorize payment directly to MCMG for my charges.

I understand that I am ultimately responsible for charges incurred at MCMG regardless of third party liability. I agree that MCMG may release any medical information necessary for filing my claim. If you do not have insurance, payment is required in full at time of service.

We accept cash, credit card or personal Check. Fees will be charged for any returned check due to insufficient funds or for any other reason the check is not accepted.

I understand and agree with the above policies of Modern Care Medical Group and I understand my responsibilities to pay all non-covered balances.

Patient's Signature: _____ **Date:** _____

(If patient is Minor)
Representative Signature_____ **Relationship:**_____