OFFICE REGISTRATION FORM

Please **PRINT** and complete all sections below.

Today's Date_____

Last Name: _____ First: _____ MI: _____ Marital Status: S M W D Sep

Date of Birth: _____ Age: _____ M or F Social Security #_____

Street Address: _____ City, State, Zip: _____

Phone (day):_____ Phone Cell: _____

Email Address: _____

In Case of Emergency:
Emergency Contact: _____ Relationship to patient_____

Phone: _____ Cell: _____

Insurance Information:

_____Medicare _____Medicaid _____HMO _____PPO _____ Self Pay Copay amount_____

PLEASE NOTE IF YOU HAVE A HMO PLAN YOU WILL NEED AUTHORIZATION

Primary Care physician:

Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Pharmacy Information:

Local Pharmacy Name: _____ Phone: _____ Fax:_____

Address: _____ City: _____ State: _____ Zip: _____

Mail Order Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment information:

Employer _____ Occupation: _____

Address: _____ City, state, Zip: _____

Phone _____

Satish Patel, M.D., P.A.
5340 Gulf Dr, Ste 105
New Port Richey, FL 34652
Tel: (727) 849-0222 | Fax: (727) 847-7685

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA OMNIBUS RULE NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Satish Patel, M.D., P.A. A copy of this signed and dated document shall be as effective as the original.

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Printed Name of Legal Representative *(if applicable)* Relationship to Patient

_____ _____
Signature of Patient *or* Legal Representative Date Signed

. . . . . .

HIPAA

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's (or legal representative's) signature on this Acknowledgement, but did not do so because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient.
- ☐ The patient refused to sign.
- ☐ The patient was unable to sign because _____.
- ☐ Other *(specify)*: _____.

Employee Name: _____ Signature: _____

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT

I, the undersigned, voluntarily give consent to Satish Patel, M.D., P.A. to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Signature of Patient/Legal Representative Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received/reviewed a copy of Satish Patel, M.D., P.A.'s Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____

Signature of Patient/Legal Representative Date

OFFICE USE ONLY		
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so for the reason documents below:		
Date	**Initials**	**Reason**

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Satish Patel, M.D., P.A. to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Satish Patel, M.D., P.A. for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Legal Representative Date