Ocala Health
Family Care Specialists

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

Employed (Please List Employer)_____ Phone # (_____) _____

If Under 18, Mother's name_____Phone (_____)_____

If Under 18, Father's name_____Phone (_____)_____

Where and when have you lived and traveled outside the U.S. and Canada? _____

Date of last eye exam_____ Doctor's name_____

Pharmacy name and phone number_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_-_____-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received Family Care Specialists' HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS 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, e.g., Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related 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 or 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 XVII/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 carriers any information needed for this or 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 THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. The assignment will remain in effect until revoked by me in writing.

V. CONSENT FOR TREATMENT – I, the below named patient, hereby give my consent for treatment to all physicians associated with Family Care Specialists

VI. CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Family Care Specialists to discuss my medical condition with, or release my medical records to, the below named person(s):

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Please remember that insurance in 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 for by my insurance or third party payor within a reasonable period of time not to exceed 60 days. If the amount 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.

DATE_____PATIENT_____
(Signature)

SUBSCRIBER (if different from patient)_____
(Signature)

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.