MERITAS HEALTH

REGISTRATION FORM

Patient's Information Today's Date _____

Primary Care Physician _____ Referring Physician _____

Patient's Legal Name: First _____ M.I. ____ Last _____

Parent's Name (if minor) _____ Patient's SS# _____ Date of Birth _____

Patient's Street Address _____ City _____ State___ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ E-mail Address _____

Patient's Gender: M or F Patient's Marital Status: S M D W Spouse Name (if applicable) _____

Race (circle one): White Black Hispanic Native American Asian/Pacific Islander Other

Ethnicity (circle one): Hispanic Non-Hispanic Preferred Language_____

Send Statements To: _____

Mailing Address _____

Patient's Employer _____ Patient's Occupation _____

Employer's Address _____ City _____ State___ Zip _____

In case of emergency notify: _____ Relationship to patient: _____

Telephone number (_____)_____ Alternate telephone number (_____) _____

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Primary Insurance

Insurance Plan _____ Phone (_____)_____

Name of Policyholder _____ Policyholder's Date of Birth _____

Policyholder's Employer _____ Phone (_____)_____

Secondary Insurance

Insurance Plan _____ Phone (_____)_____

Name of Policyholder _____ Policyholder's Date of Birth _____

Policyholder's Employer _____ Phone (_____)_____

Consent for Treatment, Assignment of Insurance Benefits, and Release of Medical Information:

I hereby authorize treatment deemed necessary by Meritas Health's physicians. I agree to assume responsibility for full payment of services provided by Meritas Health Corporation. I assign and grant to Meritas Health all my rights, title and interest in and to any insurance benefit otherwise payable to me by reason of receipt of services from Meritas Health. I further request that such benefits are made directly to Meritas Health. I understand that I am responsible for any amount not covered by insurance.

Patient Signature _____ Date _____
(Parent or Guardian, if patient is a minor)

Acknowledgment of Notice of Privacy Practices: I understand that Meritas Health may use and disclose all or any part of my medical record for purposes of payment, treatment or health care operations as summarized in the Meritas Health Notice of Privacy Practices, a copy of which has been made available to me prior to signing this document.

Patient Signature _____ Date _____
(Parent or Guardian, if patient is a minor)

Authorization for Photographs: I consent to photographs being taken for my health record.

Patient Signature _____ Date _____
(Parent or Guardian, if patient is a minor)

Consent for Alternative Communication Methods to Patients:

Meritas Health Corporation and its practices may contact you for continuing care purposes, billing purposes, or to alert you to services and events that may benefit you. These communications may include (but are not limited to):

- Appointment reminders
- Information about upcoming visits
- Notifications of information available on your Patient Portal
- Preventive care reminders
- Notifications about new services
- Events or health fairs sponsored by Meritas
- Patient account and billing reminders

I consent to receive communications from Meritas Health Corporation about my protected health information, the care I receive, my bill, and other services at the phone number(s) and e-mail address(es) I provided upon registration, including my wireless number (if provided). I understand that Meritas Health Corporation may contract with other organizations to manage or collect for the services provided to me. This consent extends to telephone communications by those organizations, as well. I understand that I may be charged for calls and text messages to my wireless number by my wireless carrier and that those calls may be generated by an automated dialing system, and may include pre-recorded messages. I understand that my receipt of healthcare services is not conditioned upon my agreement to be contacted by phone as described in this section and that I may opt out at any time by contacting a Meritas practice where I receive care.

Please indicate the method that you prefer to receive this information:

___ Phone (voice call) to number provided on Page 1 **Circle one:** Home Cell

___ E-mail to e-mail address provided on Page 1. *[By choosing this option, I acknowledge the risk of my use of unsecure e-mail and am aware that my PHI could be read or otherwise accessed by a third party while in transit and accept this potential risk of disclosure.]*

___ Text Message to cell number provided on Page 1

Patient Signature _____ Date _____
(Parent or Guardian, if patient is a minor)

If someone other than the Patient has executed the above Authorizations: Printed Name:_____
Relationship to Patient: ___Parent ___ Legal Guardian ___ Other Specify: _____