Garry Peers, MD, FRCSC , Tim Roytman, MD, FACS , Jason T. Smotherman, MD, Gregory LaNouette, MD

Patient Registration Form

PATIENT NAME: _____ DATE OF BIRTH ____ /____ /____ SS# _____ -____-_____
LAST FIRST MI

ADDRESS: _____ CITY _____ STATE _____ ZIP _____
STREET APT#

HOME#: _____ OK TO LEAVE MESSAGE AT HOME? ___ YES ___ NO CELL#: _____

EMPLOYER: _____ WORK#: _____ OKAY TO LEAVE MESSAGE AT WORK? ___ YES ___ NO

GENDER: __ MALE __ FEMALE MARITAL STATUS: ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOW ___ SEPARATED

SPOUSE'S NAME: _____ DATE OF BIRTH: ____ /____ /____ SS# ____-____-____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TEL#: _____

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

Insurance Information

1ST INSURANCE: _____ SUBSCRIBER'S NAME: _____ RELATIONSHIP: _____

Subscriber# _____ **Group#** _____ **Coverage#** _____

2ND INSURANCE: _____ SUBSCRIBER'S NAME: _____ RELATIONSHIP: _____

Subscriber# _____ **Group#** _____ **Coverage#** _____

3RD INSURANCE: _____ SUBSCRIBER'S NAME: _____ RELATIONSHIP: _____

Subscriber# _____ **Group#** _____ **Coverage#** _____

WORKER'S COMP: ___ YES ___ NO ___ DATE OF INJURY: ____ /____ /____ NO FAULT: ___ YES ___ NO DATE OF ACCIDENT: ____ /____ /____

INSURANCE ADDRESS: _____

ADJUSTER'S NAME: _____ TELEPHONE#: _____

I authorize the release of medical information to my referring physician and _____
_____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDMENT OF RESPONSIBILITY FOR PAYMENT FOR PHYSICIAN SERVICES:

I hereby give my consent to Dr. Garry Peers/Dr. Tim Roytman/Dr. Jason T. Smotherman/Dr. Gregory LaNouette to provide whatever treatment is deemed necessary. I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services. I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to Dr. Peers/Dr. Roytman/Dr. Smotherman/Dr. LaNouette for any services furnished me by him. This assignment will remain in effect until revoked in writing. I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bill submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGE AND CONSENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involve in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact his office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do disagree that you are bound to abide by such restrictions.

I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement and Consent, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____