SHIELD MEDICAL GROUP
QUICK, COMPREHENSIVE AND COST EFFECTIVE CARE

☐ New Patient
☐ Legal Name Change
☐ Insurance Change
☐ Guarantor Change
☐ Address Change
☐ Other

PLEASE PRINT

PATIENT REGISTRATION FORM

Last Name: First: Middle:	Date of Birth:	Social Security #:
Billing Address: Apt./Lot:	City:	State: Zip:
Primary Phone #: Type: ☐ Cell ☐ Land ( )	Alternate Phone(s) #: Secondary ( ) Type: ☐ Cell ☐ Land TTY ( ) Fax ( )	Preferred Method of Notification ☐ Primary Phone ☐ Alternate Phone ☐ Billing Address
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Primary Language:
Please Indicate Special Needs ☐ Blind/Visually Impaired ☐ Deaf/Hearing Impaired ☐ Language Translator ☐ Other_____		
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander	Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin	
Maiden/Previous Legal Name(s):	Mother's Current and Maiden Name, if Minor Patient:	Father's Name, if Minor Patient:
Occupation of Patient:	Employer/Company Name:	Employer Address:	Employer Phone #: ( )
Spouse's Name:	Spouse's Employer:	Spouse's Employer Address:	Spouse's Employer Phone #: ( )
Name of Person Outside of Home to Contact in Case of Emergency:	Emergency Contact Address:	Emergency Contact Phone #'s: Home ( ) Work ( )	Relationship to Patient:

If this form represents a change to your clinic account, please list names of family members whose records will need to be updated also.

Name	Sex	Birthdate	Name	Sex	Birthdate
1.			3.		
2.			4.		

INSURANCE INFORMATION

Primary Insurance:	Effective Date:	Secondary Insurance:	Effective Date:
Mailing Address:		Mailing Address:	
City: State: Zip:		City: State: Zip:	
Subscriber's Name:	Subscriber's Employer:	Subscriber's Name:	Subscriber's Employer:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Life Partner ☐ Dependent Child ☐ Other	Subscriber's Sex: ☐ Male ☐ Female / Subscriber's Birthdate:	Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Life Partner ☐ Dependent Child ☐ Other	Subscriber's Sex: ☐ Male ☐ Female / Subscriber's Birthdate:
Policy #:	Group #:	Policy #:	Group #:

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FINANCIAL AGREEMENT

Head of Household or Parent with Custody of Minor Child:		Relationship to Patient:		Responsible Party's Social Security #: – –
Mailing Address: Apt./Lot:		City:	State: Zip:	Responsible Party's Phone #: ( )
Responsible Party's Employer:	Employer's Address:	City:	State: Zip:	Employer's Phone #: ( )
Responsible Party's Occupation:		Person Completing Form / Relationship to Patient:		

RESPONSIBILITY FOR PAYMENT

As a patient/guarantor, I agree to be responsible for payment of services upon receipt of statement according to the following guidelines:

- If there is no health plan coverage or I elect to self-pay for the medical services rendered, I will be responsible for payment at the time of service or I will establish payment arrangements with Shield Medical Group Business Office.
- If my medical plan does not have a contracted arrangement with Shield Medical Group, I will assume full responsibility for any account balance not paid by my plan. This is often referred to as being "out-of-network" or having an indemnity plan.
- If my health plan is contracted (participating) with Shield Medical Group, I agree to pay all applicable co-payments on date of service, as well as all deductibles, co-insurances and non-covered benefit charges.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I authorize payment from all applicable insurance carriers directly to Shield Medical Group for the surgical and/or medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians and/or other providers for services provided during my treatment. I request that payment of authorized Medigap benefits be made to Shield Medical Group, on my behalf in making this assignment. I understand and agree that I may be financially responsible to Shield Medical Group for charges not paid by my insurance policy(ies). I authorize Shield Medical Group to use and disclose my protected health information (PHI), including sensitive information related to mental health, substance abuse, HIV/AIDS, genetic testing, hospice care and other sensitive matters as needed for payment purposes. I permit a copy of this authorization to be used in place of the original. Shield Medical Group will provide me with a copy of this form upon request.

_____ _____

Patient Signature/Guarantor

Insured's Signature (Parent/Legal Representative if applicable)

Date _____

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CONSENT

CONSENT TO TREATMENT

I consent to Shield Medical Group providing healthcare services and treatment to me. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic tests, radiology and laboratory procedures, medication administration, taking and utilizing cultures, administration of anesthetics, HIV testing, and other necessary tests, procedures and treatment. I understand that, except for emergency and extraordinary circumstances, certain procedures will not be performed without me being provided an opportunity to give informed consent for that procedure. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance. I understand that Shield Medical Group provides treatment in multiple locations, and I consent to receive treatment in any location where Shield Medical Group physicians or providers may treat me. I understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

Initial here indicating that you have read the above statement ***Patient or Patient Representative Initials*** **X**_____

CONSENT TO USE AND RELEASE PROTECTED HEALTH INFORMATION

I have received and read a copy of Shield Medical Group 's HIPAA Notice of Privacy Practices ("Notice"). The Notice describes how my protected healthcare information ("PHI") maybe used and disclosed by Shield Medical Group, its staff, and other healthcare providers that work with Shield Medical Group. I specifically authorize the uses and disclosures of my health information as described in Shield Medical Group 's Notice, which may be changed from time to time. Disclosures may be made for treatment, payment and healthcare operations purposes, and as otherwise permitted by law. For example, I authorize disclosures to my payors and others, including disclosures to business associates of Shield Medical Group, as necessary to receive payment for my care and operate Shield Medical Group 's business. I understand and agree that my PHI, including "Sensitive Information," as defined below, may be used and disclosed to other health care providers and others inside and outside Shield Medical Group that need it for purposes permitted by the Notice or applicable law. My PHI may contain information including, but not limited to information related to health plans, insurance benefits, worker's compensation programs, immunizations, medications, educational programs, state programs and registries, and employers. I understand that once my PHI is given out, it may be subject to further disclosure. It will be protected by state and federal privacy laws only if the recipients are subject to those laws. Shield Medical Group may not be responsible for how these third parties use and disclose my PHI.

SENSITIVE INFORMATION

I specifically authorize the use and disclosure of my PHI as follows: Sensitive Information includes PHI relating to particularly confidential conditions such as mental health, psychological or psychiatric conditions; genetic information and related tests; drug, alcohol and/or substance abuse; HIV/AIDS, including tests for such conditions; sickle cell anemia; hospice care; birth control and family planning; and sexually transmissible diseases (collectively, "Sensitive Information"). Psychotherapy notes and certain substance abuse records will be shared only as allowed by law. My Sensitive Information may be used and disclosed as necessary for Shield Medical Group 's treatment, payment and health care operations purposes and as described in Shield Medical Group 's HIPAA Notice. For example, Shield Medical Group personnel may share my Sensitive Information as necessary to provide services to me.

PHOTOGRAPHS

In the course of healthcare treatment, I agree that Shield Medical Group may take pictures of me for identification, treatment, and other lawful purposes. Any pictures taken by Shield Medical Group while caring for me will be treated as part of the medical record and will be subject to applicable privacy law. Shield Medical Group will not take a picture of me in the course of my treatment for any other purpose, without my written permission.

EMAIL NOTIFICATION Email address: _____

If I have provided my email address on this form or by a previous method, I agree to receive electronic notification of announcements and information from Shield Medical Group, including, but not limited to notices of data breaches, privacy notices, and other information. I agree to update my contact information with Shield Medical Group as necessary. I agree that certain emails that, in Shield Medical Group 's judgment, are not of a particularly sensitive nature may be sent by unencrypted email, which has the potential to be intercepted by unauthorized persons.

Initial here indicating that you have read all of the above statements ***Patient or Patient Representative Initials*** **X**_____

Shield Medical Group will provide me with a copy of this form upon request. This consent applies to all of my PHI, even if Shield Medical Group obtained it before or after I signed this form. By signing below, I consent to the use and release of my PHI as explained on this form.

Patient/Patient Representative Name (PLEASE PRINT)	Date Signed
Signature	Relationship to Patient (if not signed by patient) ☐ Parent ☐ Legal Guardian ☐ Other (explain authority):