YOUNG HEARTS OF YUMA
PATIENT REGISTRATION FORM

Today's Date: ________________________

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: __________________________________ First Name: ________________________________

Billing Address:____P.O.BOX#_________________

City: ____ State: ____________Zip: ____________________

Phone #:____________________________ Cell #:___________________________________

Social Security #: ____

Date of Birth: __________________ Age: ________ Sex: ______ Marital Status: ___________

Employer Name and Address:____

Work Phone #: (_______) ________-___________E-mail Address: _______________________________

Emergency Contact Name: __________________________Phone #: (_______) _________-___________

GUARANTOR INFORMATION: (List person or insured name responsible for bill)

Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent ______ Other _________

Last Name: ________________________________ First Name: ________________________________

Address:____

City: ____ State: __________ Zip: ___________________

Home Phone #: (_________) __________-_____________Social Security#________________________

Date of Birth: _________________ Age: _____Sex: Female _______ Male ________

COMPLETE FOR BILLING (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

Plan Name: _______________________________Insured's Name: ___________________________

Insured's Social Security #: ______________________Insured's Date of Birth: _________________

Policy / ID #: ___________________________Group #: _________________________

SECONDARY INSURANCE:

Plan Name: _____________________________________Insured's Name: _______________________

Insured's Social Security #: ________________________Insured's Date of Birth:________________

Policy / ID #: __________________________________Group #: ________________________

Can we leave appointment reminder calls / messages: YES or NO Home_____ Cell_____ Work_____

PATIENT REGISTRATION FORM

DISCLOSURES & CONSENTS

Patient Name: ___________________________________ Date of Birth: ________________

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to YOUNG HEARTS OF YUMA for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that YOUNG HEARTS OF YUMA is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to YOUNG HEARTS OF YUMA on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the YOUNG HEARTS OF YUMA Patient Information Privacy Policy. I hereby authorize YOUNG HEARTS OF YUMA to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a YOUNG HEARTS OF YUMA representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this
authorization at any time by notifying YOUNG HEARTS OF YUMA to that effect in writing.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my YOUNG HEARTS OF YUMA physician.

PATIENT SIGNATURE: ___________________________________ DATE: ______________________

GUARANTOR SIGNATURE: _______________________________ DATE: ______________________
(If different from patient)