Premier Senior Care – PATIENT Registration Form

Patient's Full Name (First – Middle – Last)	☐ Male ☐Female	Date of Birth (Month – Date – Year)
_____		_____

Street address:	Social Security Number	Home phone number
_____	_____-_____-_____	_____-_____-_____
_____		E-mail address:
_____		_____

INSURANCE INFORMATION

Medicare Number:	Other Insurance Company: _____
_____	Policy Number: _____Subscriber: _____
	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Other

PERSON(S) RESPONSIBLE FOR PAYMENT IF OTHER THAN SELF

Name:	Relation to patient:	
Address:		
Home phone:	Cell Phone:	Work Phone:
E-mail Address:		

IN CASE OF EMERGENCY – PLEASE LIST 2 CONTACTS

Emergency contact name:	Relation to patient:	
Home phone:	Cell Phone:	Work Phone:
Emergency contact name:	Relation to patient:	
Home phone:	Cell Phone:	Work Phone:

MEDICARE BENEFICIARY LIFETIME "SIGNATURE ON FILE"

I request that payment of authorized Medicare benefits be made on my behalf to Premier Senior Care for any services furnished me by physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for services rendered.

X_____ _____ _____

Signature of Patient or Health Care Power of Attorney | Name, if other than patient | Date

PRIVATE INSURANCE AUTHORIZATION and NOTICE OF FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits to Premier Senior Care for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I authorize the release to my insurance company or its agent any information concerning health care, advice, treatment, or supplies provided to me, for the purpose of evaluating and administering claims.

X_____ _____ _____

Signature of Patient or Health Care Power of Attorney | Name, if other than patient | Date

ACKNOWLEDGEMENT OF PRIVACY NOTICE AND PRACTICES

I have received a copy of the Notice of Privacy Practices. We <u>will</u> discuss your health with your health care power of attorney, family members and others involved in your care if requested and appropriate. If you do not want us to communicate with certain family members, please list their names:_____

X_____ _____ _____

Signature of Patient or Health Care Power of Attorney | Name, if other than patient | Date