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
_____	_____-_____-_____	_____-_____-_____
_____Apt._____	E-mail address:	Cell number:
_____	_____	_____-_____-_____

INSURANCE INFORMATION - Include copy of cards, front & back.

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:	
Phone:	E-mail Address:

IN CASE OF EMERGENCY - Please list 2 contacts & preferred phone number.

Emergency contact name:	Relation to patient:
Phone:	E-mail Address:
Emergency contact name:	Relation to patient:
Phone:	E-mail Address:

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

Physicians are required to provide a notice explaining how personal health information is kept private. I (please check one) would □ would not □ like a copy of this mailed to me. We <u>will</u> discuss your health with your health care power of attorney, and immediate family members if requested and appropriate. If your personal health information should be kept <u>private</u> from any family members, please list their names:_____

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

6.23.22