NORTH BAY FAMILY MEDICAL CLINIC

15012 LeMoyne Blvd. • Biloxi, MS 39532 • Telephone (228) 392-5050

Office Registration Form (Please Print)

PATIENT INFORMATION **Date** _____

Name of Patient _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Home Address _____
(STREET ADDRESS) (APT #) (CITY) (STATE) (ZIP CODE)

Mailing Address _____

Email Address _____

Date of Birth _____ Age _____ Sex _____ Single ____ Married ____ Divorced ____

Race: White ____ Black/African American ____ Asian ____ Other _____

Patient's Social Security Number _____

Home Phone No. _____ Cell Phone No. _____

Patient's Employer _____

Employer's Address _____
(STREET ADDRESS) (APT #) (CITY) (STATE) (ZIP CODE)

Employer's Phone No. _____

Nearest Relative or Friend _____ Phone # _____

Relationship to Patient _____

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Father's Name _____ Father's Employer _____

Father's Employer Address _____

Father's Work Phone _____ Father's S.S.# _____ Father's D.O.B. _____

Mother's Name _____ Mother's Employer _____

Mother's Employer Address _____

Mother's Work Phone _____ Mother's S.S.# _____ Mother's D.O.B. _____

Are Child's Parents (as listed above): Married _____ Divorced _____ Separated _____

SPOUSE INFORMATION

Husband or Wife's Name _____ Employer _____

Employer Address _____ Employer Phone _____

Husband's or Wife's S.S.# _____ Husband or Wife's D.O.B. _____

NORTH BAY FAMILY MEDICAL CLINIC

INSURANCE

Please check with our receptionist to see if we participate with your insurance group. We will need to copy your insurance cards in order to verify this.

Primary Insurance Company _____

lnsured's Name _____ S.S.# _____

Insurance Address _____

ID or Certificate No.: _____ Group No.: _____

Secondary Insurance Company _____

lnsured's Name _____ lnsured's S.S.# _____

Insurance Address _____

ID or Certificate No.: _____ Group No.: _____

RELEASE OF INFORMATION

I AUTHORIZE any physician to release all information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to the Insurance Company and/or its Representative. Assignment of benefits is allowed as designated by this office.

I AUTHORIZE verification of employment, residence, any and/or all facts included within this document to be released to North Bay Family Medical Clinic, P.A. I AUTHORIZE North Bay Family Medical Clinic to obtain any credit reports as necessary, for collection purposes only. A photocopy or facsimile reproduction of this authorization may be used in place of this original document.

All professional services rendered are the responsibility of the patient regardless of insurance coverage. If an account is placed for collections, there will be a 40% service fee added. It is the Patient's responsibility to pay any and all outstanding amounts due plus service fees, and fees of an attorney, court costs, collection agency and credit bureau fees.

I agree that this authorization shall be valid until rescinded in writing or replaced by one at a later date.

Date _____ Signed _____

(Patient, Parent, or Legal Guardian Signature)

(Relationship to Patient) _____

NORTH BAY FAMILY MEDICAL CLINIC

HIPPA AND AUTHORIZATION FOR PAYMENT

Thank you for choosing North Bay Family Medical Clinic for your medical care. The following are some of our office policies in regard to insurance and payment.

- It is your responsibility to know if the doctor you are seeing is listed on your current insurance plan, otherwise YOU will be responsible for all charges.
- If you have a copayment for doctor visits, it must be paid at check-in before seeing the doctor.
- Full payment is due at the time of service if insurance does not apply.
- If your doctor refers you to a specialist, your insurance company may require preapproval. You must check with your insurance company to see if this applies.

I hereby authorize payment to NORTH BAY FAMILY MEDICAL CLINIC, P.A., and authorize release of all medical information to secure payment. This form constitutes "My Signature on File" for the purpose of filing a claim with my msurance.

I hereby give my consent for North Bay Family Medical Clinic to use and disclose protected health information about me to carry out treatment, payment, and health care operations (TPO).

North Bay Family Medical Clinic may call my home and leave a message on my answering machine or voice mail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations. I acknowledge that I have received the "Notice of Privacy Practices" which describes such uses and disclosure more completely.

By signing this form, I am consenting to allow North Bay Family Medical Clinic to use and disclose my private healthcare information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, North Bay Family Medical may decline to provide treatment to me.

PRINT PATIENT NAME _____

Date _____ Signed _____

NORTH BAY FAMILY MEDICAL CLINIC

RELEASE OF INFORMATION TO THIRD PARTY

THIS SECTION MUST BE SIGNED REGARDLESS IF YOU LIST ANY THIRD PARTY

I authorize North Bay Family Medical Clinic to address any and/or all inquiries in regards to my appointments, messages, account activity, and/or any medical inquiries or conditions with the following persons:

Print Name of Person _____ Relationship to Patient _____

Print Name of Person _____ Relationship to Patient _____

PATIENT NAME _____

Date _____ Signed _____

AUTHORIZATION OF RELEASE FOR MEDICAL CARE

I authorize the persons below to accompany _____ (minor child) for appointments and give my permission for medical care to be administered.

Print Name of Person _____ Relationship to Patient _____

Print Name of Person _____ Relationship to Patient _____

PARENT, or LEGAL GUARDIAN SIGNATURE _____

Date _____