

**The Clinic at Elm Lake, PA**  
**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Patient's E-mail \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Spouse's Name \_\_\_\_\_ Divorced \_\_\_ Widowed \_\_\_

Emergency Contact \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Carrier \_\_\_\_\_ Policy or ID # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health plans to The Clinic at Elm Lake, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure the payment.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payment, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

**Patient Consent for Use and Disclosure of Protected Health Information:**

- I hereby give my consent for The Clinic at Elm Lake, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by The Clinic at Elm Lake, PA describes such uses and disclosures more completely.)
- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Clinic at Elm Lake, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Stephanie M. Gale, CFNP • The Clinic at Elm Lake, PA • 3700 N Frontage Rd • Columbus, MS 39701**

- With this consent, The Clinic at Elm Lake, PA may call my home or other alternative location and leave a message on voice mail (unless a Refusal to Allow Voice Mail Form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- With this consent, The Clinic at Elm Lake, PA may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
- By signing this form, I am consenting to allow The Clinic at Elm Lake, PA to use and disclose my PHI to carry out 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, The Clinic at Elm Lake, PA may decline to provide treatment.

\_\_\_\_\_  
**Printed Patient Name**

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**