Account Number _____

PATIENT REGISTRATION FORM

Neurosurgery of
North Iowa, P.C.

Date_____

Name (Last, First, Middle)_____SSN#_____ DOB_____

Primary Language_____Race_____Ethnicity_____ Sex __M__F___

Local Address_____ City _____ State_____ Zip _____

Secondary/Billing Address (if applicable)_____

Phone (home)_____ (day)_____ (cell) _____

Email Address _____

Emergency Contact Name _____ Contact phone_____ Home phone _____

Referring Physician_____ Primary Care Provider _____

Employer Name:_____

Address:_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____Plan Name:_____

Address: _____Telephone No.:_____

Subscriber Name:_____Group No: _____ Individual No:_____

Subscriber Date of Birth **(must include)**_____

Secondary Insurance Company Name: _____Plan Name:_____

Address: _____Telephone No._____

Subscriber Name:_____Group No: _____ Individual No:_____

Other Insurance Company Name: _____Plan Name:_____

Address: _____Telephone No._____

Subscriber Name:_____Group No: _____ Individual No:_____

ACCIDENT CASES: Date of accident:_____Workers Comp ( ) Auto ( ) Liability ( ) Other ( )
( ) Yes ( ) No Has the insurance company been notified?

Name of Company_____ Address:_____

Contact Name:_____ Telephone No:_____

( ) Yes ( ) No Have you received a claim Number? Claim Number _____

MERCY CLINIC
PATIENT INFORMATION

Please take time to read and understand each of the consent statements listed below. When you return to the desk to complete the check in process you will be asked to verify your personal information on this consent and sign in agreement. Thank You.

I, the undersigned patient or person responsible for the undersigned patient, knowing that I, or the patient, suffer from a condition requiring medical care, do hereby voluntarily consent to such medical care by Mercy Clinic, encompassing routine diagnostic procedures and medical treatment by the provider, his/her assistants, or his/her designees as is necessary in his/her judgment.

I understand that the Hospital will record my information in an electronic health record. I consent to the sharing of this information for patient care, payment, patient safety and quality of care purposes by hospitals and clinics that participate in the Mercy Health Network-North Iowa.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the clinic. I do acknowledge and consent to examination and treatment by the provider for Mercy Clinic.

I hereby assign Mercy Clinic all benefits otherwise payable to me under the medical expense provision on my insurance/Medicare benefits or so much thereof as may serve to satisfy my indebtedness to said clinic. I agree that, should the amount be insufficient to cover my entire medical expense, I will be responsible for payment of the difference and that if my disability were such that it is not covered by the policy contract, I will be responsible to said clinic for the payment of the entire medical bill.

I further authorize Mercy Clinic, members of the staff, administrators, nurses, and officials of the said clinic to furnish to my health insurance company or its representatives any information pertaining to the illness or injuries sustained by me and the treatment thereof for which I received medical care at said clinic.

I agree that Mercy Clinic, including our business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in charges to me. I may also be contacted by text messages or e-mails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.

_____ _____

Patient Signature/Representative Relationship to Patient

_____ _____

Witness Date

Acknowledgment of Provider's Notice of Privacy Practice

I acknowledge:

When presenting for healthcare services the Provider's Notice of Privacy Practices was given to me to read or to take with me.

The Notice was clearly posted in a prominent location where I was able to read the Notice of Privacy Practices.

If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment was completed.

I received the Notice of Privacy Practices during the first day I received health care services after April 14th, 2003.

Patient Signature _____ Date _____ Representative/Guarantor _____ Relationship to Patient _____

Patient Name _____ MR# _____ Witness to Signature _____ Date _____

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: _____

Date of attempt to obtain Acknowledgment: _____

Reason Acknowledgment was not obtained **(describe reason, such as an emergency treatment situation or substantial barrier to communication):**

_____

_____

_____

_____ _____

Signature of Workforce Member Date