Patient Registration Form

Demographic Information

Name:_____ **Date of Birth**:_____ **Sex**: M ☐ F ☐

SS #:_____ **Home Phone #**: _____

Cell Phone #:_____ **Work Phone #**: _____

Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____

Email address:_____ **Preferred language**:_____

Race: Caucasian Hispanic African American Biracial Asian Other:_____ Decline

Ethnicity: Hispanic Non-Hispanic Decline **Marital Status**: Single Married Widowed Divorced

Employer: _____ **Address**: _____

Emergency Contact: _____**Relationship**:_____**Phone #**:_____

Authorized to Disclose Health/Billing information to emergency contact? ☐ Yes ☐ No

Insurance Information

Primary Insurance:_____ **ID #**:_____ **Group #**:_____

Subscriber:_____ **Relationship to Subscriber**:_____

Subscriber's Date of Birth:_____

Secondary Insurance:_____ **ID #**:_____ **Group #**:_____

Subscriber:_____ **Relationship to Subscriber**:_____

Subscriber's Date of Birth:_____

Appointment related to a work injury or an auto accident?

Type: ☐ Auto Accident ☐ Worker's Comp ☐ Legal/Employer ☐ Other **Date of accident/injury**:_____

State of accident/injury:_____ **Auto Accident/Worker's Comp Insurance Carrier**:_____

Phone #: _____ **Address**: _____ **City**:_____

State:_____ **Zip Code**:_____ **Auto Insurance/Worker's Comp Claim #**:_____

Adjuster's name:_____ **Phone #**: _____

Signed: _____ **Date:** _____ **Relationship to Patient:** _____

Patient name (print): _____ **Date of Birth:** _____

CONSENT FORM FOR THE AUTHORIZATION OF TREATMENT & RELEASE OF INFORMATION

Consent for Medical / Surgical / Urgent Care

I hereby authorize Shore Physicians Group, PC to provide initial and ongoing medical / surgical treatment that is necessary and reasonable as based on acceptable standards of care for my wellness and the treatment of my physical condition.
I consent to examinations, blood tests, laboratory procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician, and their associates and assistants, or rendered by facility personnel under the instructions, orders and direction of such physician(s).

Consent for Telehealth/Telemedicine Services

Telehealth/Telemedicine involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that: I will be informed of any other people who are present at either end of the telehealth/telemedicine encounter and have the right to exclude anyone from either location. All confidentiality protections required by law or regulation will apply to my care. I have the right to refuse or stop participation in telehealth/telemedicine services at any time and request alternative services such as an in-person appointment. However, I understand that the equivalent in-person services might not be available at the same location as the teleheath/telemedicine services. If I do not want to receive health care services by telehealth/telemedicine, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled. If an emergency occurs during a telehealth/telemedicine encounter, 911 will be called and your Provider will stay on the video until help arrives. Potential risks include, but may not be limited to, delays due to complications or difficulties related to connectivity or equipment, in rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making, delays in evaluation could occur due to deficiencies or failures of the equipment and although highly unlikely, security protocols can fail, causing a breach of privacy.

Authorization to Release Medical Information

I hereby authorize Shore Physicians Group, PC to release information obtained in the course of my medical / surgical / urgent care to my insurance carrier and other providers of healthcare and healthcare organizations involved in my care. In the event of an employee blood or body fluid exposure I authorize Shore Medical Center to release pertinent testing for the treatment of the employee. I also authorize Shore Physicians Group to receive my medication history. I agree, in order for Shore Physicians Group to service my account to collect any amounts owed, Shore Physicians Group and its affiliates, may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Shore Physicians Group and its affiliates, may also contact me by sending text messages or emails, using any email address I provide.

Assignment of Benefits

I hereby assign all medical / surgical / urgent care benefits to which I am entitled, including major medical benefits, Medicare, private insurance and any other health plans, to Shore Physicians Group, PC. A photocopy of this assignment is to be considered as valid as the original.
I understand that I am financially responsible for all costs not covered by my insurance plan(s). This includes but not limited to co-pays, coinsurances, deductibles, and non-covered procedures and / or diagnoses. I understand that if my insurance requires a referral for me to receive treatment here, that is my responsibility to obtain that referral from my primary care physician. I also understand that I am expected to make payment for previous balances or balances sent to collections prior to my office visit. If I am unable to pay my balance in full, I understand that I can speak to the office manager to set up a payment plan.

I understand that Shore Physicians Group reserves the right to impose a fee for uncancelled (failure to show) appointments.

I authorize the release of information including the diagnosis, records & examinations rendered to me as well as claims information, to the persons listed below:

Name: _____ **Relationship:** _____

Phone number: _____

Name: _____ **Relationship:** _____

Phone number: _____

Patient or Legal Representative Signature: _____**Date:** _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of Shore Physicians Group's Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any question regarding Shore Physicians Group's Notice of Privacy Practices, please contact our Privacy Office at (609) 653-3812.

I acknowledge receipt of Shore Physicians Groups Notice of Privacy Practices.

Signature of Patient or Legally Authorized Representative: _____

Date: _____

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Attempts have been made to obtain written acknowledgement of receipt of Shore Physicians Group's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Barrier(s) to communication prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify)

Signature of Provider Representative: _____

Date: _____

SHORE PHYSICIANS GROUP℠

PATIENT ID/LABEL HERE:

HEALTH INFORMATION REQUEST FORM

This form is used to have your health information sent **from** another healthcare provider to Shore Physicians Group.

Patient's Name_____

Date of Birth: _____Social Security Number: _____

I hereby authorize (Please ***print***):

Name of Healthcare Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

TO RELEASE THE FOLLOWING HEALTH INFORMATION TO

Provider:_____

Attn: _____

Contact Phone #: _____ **Contact Facsimile #:** _____

Please check off (√) the information needed:

☐	Face Sheet	☐	EKG
☐	Discharge/Transfer Summary	☐	EEG
☐	History and Physical Exam	☐	Radiology Report(s)
☐	Operative Report	☐	Laboratory studies
☐	Pathology Report(s)	☐	Progress Notes
☐	Consultation Reports	☐	Prescriber Orders
☐	Other: _____		

Dates of Treatment: _____, _____, _____

Comments: _____

The purpose of this disclosure is to assist Shore Physicians Group with the continuity of my care. I may revoke this authorization at any time. However, I also understand that such a revocation will not have any effect on any information already used or disclosed.

This authorization will remain in effect for 90 days unless otherwise specified below: (*Initial the applicable box)*

_____ From the date of this form until the _____ day of _____, 20___

_____ Until the following event occurs: _____

_____ _____

Patient's Signature | Signature of Patient's Legally Authorized Representative

_____ _____ _____

Date | Time | Relationship to Patient