PATIENT REGISTRATION FORM

PREFERRED LANGUAGE_____

TRANSLATOR REQUIRED? YES____ NO____

PATIENT INFORMATION:

PATIENT'S NAME_____
LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY NUMBER_____ D.O.B._____ SEX_____ RACE_____

MARITAL STATUS_____ MAIN PHONE_____ ALTERNATE PHONE _____

BEST CONTACT PHONE NUMBER _____ EMAIL ADDRESS _____

IS IT OK TO LEAVE A MESSAGE ON THIS NUMBER? YES___ NO___ BEST TIME TO CALL YOU _____ AM PM

PATIENT'S ADDRESS_____
STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS, IF DIFFERENT _____
MAILING / PO BOX CITY STATE ZIP

GUARANTOR INFORMATION: (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME_____
LAST FIRST MIDDLE INITIAL

GUARANTOR D.O.B._____ GUARANTOR SOCIAL SECURITY NUMBER _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT: PATIENT OR GUARANTOR (CIRCLE ONE)

EMPLOYER'S NAME _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

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WOULD YOU LIKE TO APPLY FOR REDUCED FEE SCALE? YES _____ NO _____

Any patient who desires reduced fees for services will be interviewed to determine eligibility. Appropriate documentation of financial information is required.

ANNUAL CONSENT FORM

☐CONSENT FOR TREATMENT AND INSURANCE

I hereby give permission for the medical and /or dental staff of MCR Health to treat and prescribe medications, as they feel necessary on me or my ☐ Child ☐ Spouse. I, as parent, legal guardian or responsible adult, must accompany my child to MCR Health and stay with them throughout the entire examination.

My spouse has either given me permission to request treatment from MCR Health on his/her behalf or has been granted by a court of competent jurisdiction and I will submit the authority to MCR Health.

This consent is freely and voluntarily entered into authorizing MCR Health to release any of the following information to my insurance company or any other paying source in order that direct payment can be made to the above institution in my behalf. I hereby agree and covenant that in consideration for the treatment of me or my ☐ Child ☐ Spouse, I will pay the cost of this said treatment.

Signature:_____ Date: _____

Relationship to patient:_____

☐ MEDICAID RELEASE OF INFORMATION (Copy of Card Must Accompany Release Form)

I certify that I am a recipient of Medicaid Program and request that payment and authorized benefits be made on my behalf. I authorize MCR Health and my insurance carrier to make available to the Florida Division of Family Services and requested information concerning medical insurance and financial records relating to my medical care. I hereby certify all insurance shall be assigned to MCR Health for services provided.

_____

Client Signature Date

☐ MEDICARE LIFETIME AUTHORIZATION (Copy of Card Must Accompany Release Form)

I request that payment of Authorized Medicare benefits be made to either me or on my behalf for the services furnished me by MCR Health. I authorize any holder of medical or other information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____

Client Signature Date

☐ AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I hereby authorize: MCR Health

To Disclose to: Manatee Board of County Commissioner – Community Services Department or Grantor of Ryan White Funding or Florida Department of Health or Manatee County Health Department.

For the purpose of: Monitoring or Auditing

_____My entire medical record and any other personal health information concerning me as required by paying source contract, to include any medical files and notes, laboratory results, diagnostic tests/studies, x-rays, diagnosis and treatment of HIV/STD's, diagnosis and treatment of mental illness, alcohol/substance abuse, Psychotherapy/Psychological notes, Case Management files and documents, Pharmacy records, Billing records.

_____Except for the following which expressly may not be disclosed (if none, please write None): _____

_____

All information I hereby authorize to be released will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that I may withdraw this consent at any time.

Signature of client or legal guardian:_____ Date: _____

Use this space only if client withdraws consent

Signature of client or legal guardian: _____ _____

Date consent was revoked

PATIENT REGISTRATION FORM

PATIENT NAME: _____ **Date of Birth:** _____

1. Are you homeless? _____ Yes _____ No

2. Are you a veteran? _____ Yes _____ No

In the past two years or prior to retirement or disability have you or the "Head of Household":

3. Have you or the head of household worked in agricultural: planting, tilling, harvesting, or packing crops grown on the land such as fruits and vegetables?

_____ Yes _____ No → Stop here
↓ (Go to # A)

A. Did you or the head of household move from this area to another county or state in search of agricultural work?

_____ Yes → Migrant Farm worker

_____ No ↓ (Go to # B)

B. Has your family lived in this area and earned more than half their income from seasonal agriculture?

_____ Yes → Seasonal Farm worker

Patient/Guarantor Signature _____ Date: _____