REGISTRATION PAPERWORK - [Location Name]

Patient Legal Last Name	Patient First Name	MI	Date of Birth (MM/DD/YYYY)

PATIENT INFORMATION

Preferred Name: _____ **Social Security Number**: _____
Address: _____ **City, State:** _____ **Zip:** _____
Home Phone Number *(landline)*: _____ **Cell Number:** _____
Sex at Birth (please choose one): ☐ Female ☐ Male **Email Address**: _____
Do you have an advance directive? ☐ **Yes** ☐ **No** *(an advance directive is a written statement of a person's wishes regarding medical treatment should the person be unable to communicate it, often including a living will.)*

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ other: _____
Race: ☐ Black/African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ American Indian or Alaska Native ☐ declined to specify ☐ Other: _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ declined to specify
Gender Identity: _____ **Preferred Pronoun:** _____
Preferred Pharmacy Name: _____ **Pharmacy Phone Number**: _____
Pharmacy Address: _____ **City, State:** _____ **Zip:** _____
Primary Care Physician First and Last Name: _____
Referring Provider First and Last Name *(if applicable)*: _____

RESPONSIBLE PARTY INFORMATION (information for payment)

☐ **Self** *(if checked "self", please move to the "Insurance Information" section below)* **OR**
☐ **Guarantor** *(person who is financially responsible for a patient's medical bills i.e. parent, legal guardian, or someone else)*

Provide the following information about the Guarantor *(provide only if different from patient/self):*
Last Name: _____ **First Name:** _____ **MI:** _____
Date of Birth mm ____/dd___/yyyy: _____ **Responsible Party Birth Sex:** _____
Social Security Number: _____
Relationship to Patient: _____
☐ **Check here if Guarantor's address and number is same as patient.**
(if checked, move to the "Insurance Information" section, otherwise provide number/address below)
Cell (contact) number: _____
Address: _____ **City, State:** _____ **Zip:** _____

INSURANCE INFORMATION

Is this visit related to a work-related injury (workers comp)? ☐ Yes or ☐ No
Do you have insurance? ☐ Yes or ☐ No **Do you have a secondary insurance?** ☐ Yes or ☐ No
Please provide **ALL insurance cards to the front desk**

EMERGENCY CONTACT INFORMATION

Emergency Contact Last Name: _____ **First Name:** _____
Relationship to Patient: _____ **Home Phone Number (landline):** _____
Cell Number: _____ ☐ **Check here if address is same as patient** *(or provide below)*
Address: _____ **City, State:** _____ **Zip:** _____

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GENERAL CONSENT TO TREAT

I understand that I have the right to be informed about my condition and the recommended surgical, medical or diagnostic procedure to be used so that I may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in my care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I consent to reasonable and necessary medical examinations, testing and treatment, which may include testing for communicable diseases such as HIV or AIDS. By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my healthcare clinician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my healthcare clinician, I am encouraged to ask questions. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I consent to allowing residents and other supervised individuals enrolled in a healthcare professional education program as part of their training in health care education to participate in and/or observe the delivery of my medical care and treatment.

CONSENT TO TREATMENT USING TELEMEDICINE

I consent to treatment involving the use of electronic communications (“Telemedicine”) to enable health care providers at different locations to share individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks, and no results can be guaranteed or assured. These risks include but are not limited to technical problems with information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

SHARED ELECTRONIC SYSTEM

This location uses an Electronic Health Record that will update all demographics/contact information to all our affiliated locations which share an electronic health record for which I have a relationship.

My consent to access the location’s Electronic Health Record’s Patient Portal shall be considered separate and apart from the consent in this form.

OPEN PAYMENTS DATABASE

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

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USE OF ARTIFICIAL INTELLIGENCE

I understand that treatment, processes, and certain related functions of the location may involve the use of artificial intelligence-enabled or -enhanced technologies, including for example analysis of large data sets in order to identify and predict patterns and/or systems that can abstract and process information automatically (collectively, "Artificial Intelligence"). Such treatments, processes, and related functions may also involve processes, procedures, or reports that are assisted by Artificial Intelligence. The location uses Artificial Intelligence systems as part of their commitment to improving treatments, processes, and related functions, which can help increase accuracy, reliability, speed, and safety of services.

FINANCIAL AGREEMENT

I understand that the location may bill an insurance company offering coverage. Regardless, in consideration for the services rendered and except where prohibited by law, I (the Patient or Guarantor) agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements. I understand that in the event that any amounts paid by me are ultimately greater than my final patient responsibility, such amounts may be applied to patient responsibility on other unresolved accounts prior to refund. I understand that while an estimate may have been provided prior to services, estimates may vary significantly from final charges based on a variety of factors. An itemized billing statement is available upon request and free of charge.

If supplies and services are provided to patients who have coverage through a governmental program or through certain private health insurance plans, the location may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the location's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the location.

ASSIGNMENT OF BENEFITS

I assign all my rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorize direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient. I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

I hereby irrevocably appoint the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies for any and all benefits due to me for the payment of charges associated with services and treatment rendered by the Provider. These authorized actions include administrative and non-administrative appeals of any denial or underpayment of benefits or coverage, litigation, other forms of dispute resolution in any forum or for any type of relief (including monetary and equitable) available under applicable laws, including without limitation all provisions of the Employee Retirement Income Security Act of 1974, on my behalf against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party"). I also transfer and assign to the Provider all of my rights to demand and receive the production of or access to any documents or information, including without limitation, copies of health plan documents and materials, from any entity or person to the fullest extent of my rights to do so under my health plan and applicable laws. The foregoing rights are assigned in their entirety without limitation and without reservation of any part or aspect thereof. This assignment shall not be construed as an obligation of the Providers to

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pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT

I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the Provider by the Medicare or Medicaid Program.

THIRD PARTY COLLECTION

I acknowledge location may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

CONSENT TO PHOTOGRAPHS, VIDEO, AND DIGITAL/AUDIO RECORDINGS

I acknowledge that the location security, quality improvement, patient care, healthcare operations and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded and consent to such images and recording. I understand that the location retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.

ACKNOWLEDGEMENT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

I also understand that I have certain responsibilities such as providing complete health history and treating the clinicians and staff with respect and consideration.

WEAPONS/DRUGS/EXPLOSIVES

I understand and agree that if the location at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the location may call law enforcement authorities.

USE AND DISCLOSURE OF INFORMATION

I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations, public health and other purposes permitted by applicable law. Information covered by this consent specifically includes, without limitation, history and physical records, emergency records, laboratory reports, physician progress notes, nurse notes, discharge summaries, immunization records, genetic information, psychological information, psychiatric information, intellectual disability information, and information about substance abuse disorder and chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. This consent applies, without limitation, to uses and disclosures for coordination of care or for case management purposes; to any person or entity liable for or involved in payment on Patient's behalf including to verify coverage; and to my employer's designee when the services delivered are related to a worker's compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Provider participates, or may in the future participate, in Health Information Exchanges (HIEs), data or immunization registries, or other organizations with healthcare providers, insurers, public health agencies, immunization registry users, and/or other health care industry participants and their subcontractors in order to share health information for treatment, payment, health care operations and other purposes permitted by law. Unless I notify Provider in writing that I desire to opt out of participation, I consent to health information about me being shared with participants in HIEs and other organizations as described above. Although I may opt out of immunization registries in some states, I agree that

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Provider may share my information with immunization registries.

NOTICE OF PRIVACY PRACTICES

_____ **(Patient/Representative initials)** I acknowledge that I have received the location's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

CONSENT TO TELEPHONE CALLS, EMAIL, OR TEXT MESSAGE

_____ **(Patient/Representative initials)** By opting in to receiving texts and emails, I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information), if I consent to patient reminders and other healthcare texts and emails, to receiving information from HCA Healthcare and its affiliates and service providers ("HCA") relating to my healthcare services and financial obligations, including, but not limited to: (I) healthcare-related information, including appointment reminders, treatment and follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, information about my condition(s), diagnosis, treatment plan, available treatment options and capabilities, programs or services that might be of interest to me, invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to Patient billing information. If I consent to marketing texts and emails, I also authorize the use of the email address and telephone number I provide to receive marketing and promotional materials that may be of interest to I from HCA.

I expressly agree and consent that HCA may contact me by telephone, on a recorded line, using pre-recorded or artificial voice messages, and/or using automated dialing technology. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging may be unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include name, date/time of appointments, physician/location name, physician/practice specialty, patient account number or other information related to financial obligation or our services. Message frequency may vary, and message and data rates may apply to text messages. Additional text messaging terms may be located on HCA's website and may be updated from time to time. I understand I can withdraw my consent at any time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can follow the opt-out instructions included in the message, but I may continue receiving text messages of other types subject to separate opt-out procedures.

I understand that consent is not a condition for me receiving any healthcare services. For more information, please review the Notice of Privacy Practices and Terms of Use.

COMMUNICATIONS ABOUT MY HEALTHCARE/ DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care (see below). I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

I have the option to designate a family member or another individual with whom the provider is authorized to discuss my medical condition. By listing such individuals below, I grant permission for my Protected Health Information (PHI) to be disclosed to them for the purpose of communicating medical results, findings, and care-related decisions. In

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the future, I (Patient/Representative) may revoke or modify this specific authorization and that revocation or modification must be in writing.

Please designate specific people or indicate "none".

	Name	Relationship	Contact Number
1:			
2:			
3:			

PRESCRIPTION ORDER PICK UP

I may need a friend or family member to pick up a prescription order (script) from this location. In order to release a prescription script to my designee, this location will need to have a record of their name. Prior to release of the script, my designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) ***I want*** to designate the following individual(s) to pick up a prescription order on my behalf:

Name	Relationship to Patient

OR

____ (Patient/ Representative Initials) ***I do not want*** to designate anyone to pick up my prescription order.

ACKNOWLEDGEMENT

I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

If I am signing as legal guardian, I acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

Patient/Representative PRINT NAME (please write legibly)	Date
Patient/Representative Signature	**Relationship to Patient** (*self, parent, spouse, legal guardian/representative, sibling, healthcare power of attorney, guarantor, etc.)*