NEW PATIENT REGISTRATION

Patient Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Birth Date: _____ SSN: _____

Gender: ❑ Male ❑ Female Ethnicity/Race: _____ Preferred Language: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed U.S. Military/Veteran? ❑ Yes ❑ No

Mailing Address: _____
street *city* *state* *zip*

Phone Number(s): _____
home *mobile* *work*

Email Address: _____

Emergency Contact: _____ Phone: _____ Relation to Patient: _____

Is the patient employed? ❑ Yes ❑ No ❑ Student If yes/student: ❑ Full time ❑ Part time

Employer: _____ School: _____

Person Completing form if not patient: _____ Relation to patient: _____

Were you referred to LCAM? ❑ Yes ❑ No ❑ Self-Referred

Referring Provider: _____ Phone: _____

Primary Care Provider :_____ Phone: _____

MINORS ONLY - GUARANTOR INFORMATION

Mother's Name: _____ Father's Name: _____

Person responsible for Bill: _____

SSN: _____ Relation to patient: _____ DOB: _____

Address: _____ Employer: _____

INSURANCE

Primary Insurance

Insurance Company: _____

Name of Subscriber: _____

Relation to Patient: _____ SSN: _____

Address: _____

City/State/Zip: _____

Policy #: _____ Group #: _____

Place of Employment: _____

Insured Gender: ❑ M ❑ F Date of Birth: _____

Secondary Insurance

Insurance Company: _____

Name of Subscriber: _____

Relation to Patient: _____ SSN: _____

Address: _____

City/State/Zip: _____

Policy #: _____ Group #: _____

Place of Employment: _____

Insured Gender: ❑ M ❑ F Date of Birth: _____

Authorizations and Acknowledgements

Patient Name: _____
First Middle Last

Acknowledgement of Notice of Privacy Practices

Initial Here _____ I, the patient or authorized representative of the patient, acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here _____ I, the patient or authorized representative of the patient, am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse or other health care professionals in this clinic. I also consent to any medical procedures, x-ray, laboratory tests, or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here _____ I, the patient or authorized representative of the patient, authorize the Mississippi Center for Advanced Medicine to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I, the patient or authorized representative of the patient, authorize payment directly to the Mississippi Center for Advanced Medicine for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible.

Communications Regarding My Account

Initial Here _____ I, the patient or authorized representative of the patient, agree that the facility or any other collection or servicing agency or agencies retained by the facility to collect any money that I owe to the facility may contact me by telephone, text message, email, or letter.

I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below.

Name	Relationship

_____ _____
Signature of patient/parent/guardian/person authorized to represent the patient Date

How you heard about us: _____