Mississippi Center for Advanced Medicine

NEW PATIENT REGISTRATION

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

Preferred Name: _____ Birth Date: _____ SSN: _____

Gender: _____ Ethnicity/Race: _____ Preferred Language: _____

Marital Status: _____ U.S. Military/Veteran? _____

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

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

Email Address: _____

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

Is the patient employed? _____ Is the patient a student? _____

Employer: _____ School: _____

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

Were you referred to MCAM? _____

Referring Provider: _____ Location: _____

Primary Care Provider :_____ Location: _____

MINORS ONLY

GUARANTOR INFORMATION

*Guarantor is a parent or guardian responsible for minor and anything insurance does not cover

Mother/Guardian's Name: _____ Father/Guardian's Name: _____

Person responsible for Bill (guarantor, NOT insurance): _____

SSN: _____ Relation to patient: _____ DOB: _____

Address: _____ Employer: _____

myChart

Online patient portal – send your healthcare team messages, see test results, make/confirm appt, see medications, see your bill and more!

Since patient is a minor, they will have to have an adult as a "proxy" to set up and have access to this account.

Who should have access to myChart? : _____ Relation to Patient: _____

Proxy's DOB: _____ SSN: _____ Phone #: _____

Email Address: _____

PLEASE TURN OVER TO COMPLETE →

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INSURANCE

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Name of Subscriber: _____	Name of Subscriber: _____
Relation to Patient: _____ SSN: _____	Relation to Patient: _____ SSN: _____
Subscriber Address: _____	Subscriber Address: _____
City/State/Zip: _____	City/State/Zip: _____
Policy #: _____ Group #: _____	Policy #: _____ Group #: _____
Place of Employment: _____	Place of Employment: _____
Subscriber Gender: _____ Date of Birth: _____	Subscriber Gender: _____ Date of Birth: _____

AUTHORIZATIONS & ACKNOWLEDGEMENTS

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