Inverrary Medical Center, PA
3161 Inverrary Blvd. W
Lauderhill FL 33319
(954)748-2977

Today's Date: ______________________ ( ) NEW ( ) UPDATE

Patient Registration Form

Last Name: __________________________ First Name: ______________________________ M.I. ____________
Date of Birth: _________________
Preferred Name: ______________________ Alias or Maiden Name_____________________________________
Address: ____
Home Phone: _____________________ Work Phone: ____________________ Cell: ________________________
Sex: M/F: _____ Marital Status: _____________ Social Security #:
____
Other Family Members Seen by Us: ____
Email: ____

May we contact you regarding special events such as Free HIV, Mammograms, etc….? Yes ☐ No ☐

Employer's Name: _________________________ Occupation: ____
Address: ____
Work Phone: _______________________

Insurance Information

Primary Insurance: ____
Subscribers Name: ________________________ Subscriber's Soc. Sec #: ___________________
Relationship to Subscriber: ________________ Subscriber's Employer: ____________________
Subscriber's DOB: _________________ Subscriber's ID: __________________________
Group #: _________________________ Insurance Address: ________________________

Secondary Insurance: ____
Subscribers Name: _____________________ Subscriber's Soc. Sec. #: ___________________
Relationship to Subscriber: _______________ Subscriber's Employer: ____________________
Subscriber's DOB: ____________________ Subscriber's ID: __________________________

Emergency Contact

Name: _______________________________________ Relationship: _____________________________________
Address: ____
Home Phone: ____________________ Work Phone: _____________________ Cell: ________________________

How did you hear about us? ____

I authorize treatment and the performance on myself or (this patient as their legal guardian) of diagnostic procedures such as laboratory studies, x-rays and others as required. I also authorize the performance of therapeutic procedures such as minor surgical procedures, injections or other therapeutic modalities I accept responsibility for the medical charges incurred, and agree to pay all bills at the time of service unless other arrangements are made. I also agree to pay all expenses associated with collecting outstanding balances that are not paid within the agreed time. I authorize the release of any medical information necessary to process the claim and request the payment of all benefits are made directly to Inverrary Medical Center Practitioners. I understand the information released may include records in these subject areas: HIV/AIDS, sexually transmitted disease, mental health treatment, and drug and alcohol abuse treatment. I also authorize my insurance claim to be paid directly to this facility. I, the patient or guarantor, certify that the information on the form is true to the best of my knowledge.

______________________________________ ______________________________
GUARDIAN AND/ OR PATIENT SIGNANTURE **DATE**

ASSIGNMENT OF BENEFITS

I authorize Inverrary Medical Center and its qualified healthcare professionals providing care to collect directly from my insurance carrier, health plan, Medicare or Medicaid any payment due for services rendered onto me, during the course of my treatment at Inverrary Medical Center. Any amounts not paid by the health plan will be paid by me. I authorize Inverrary Medical center and any of its healthcare professionals or staff to act as attorney in fact in the collection of benefits from any third party through whatever means may be necessary including the filing of suit. I recognize that Medicare and Medicaid have certain co-payments that I must pay per visit. This shall serve to me as notice of such and I assume responsibility for ascertaining that I make such payments now and in the future.

____
Patient and/or Guardian Initials

CONSENT FOR RELEASE OF INFORMATION

I authorize the release of information contained in my medical records acquired in the course of my examination or treatment to insurance carriers, health plans and other providers as may be needed by Inverrary Medical Center in compliance with HIPPA. I have received and reviewed Inverrary Medical Center information policies and procedures as required by HIPPA.

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Patient and/or Guardian Initials

CONSENT FOR TREATMENT AND TESTING

I authorize treatment and the performance on myself or (this patient as their legal guardian) of diagnostic procedures such as laboratory studies, x-rays and others as required. I also authorize the performance of therapeutic procedures such as minor surgical procedures, injections or other therapeutic modalities.

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Patient and /or Guardian Initials

ADVANCED DIRECTIVE

I have received information from Inverrary Medical Center regarding my right to have an advanced directive or a living will:

( ) I have executed an advanced directive document
( ) I have not executed and advanced directive document the foregoing, has been advised of their right to seek legal counsel prior to signing this form and has declined such offer. The undersigned is duly authorized to execute this form on behalf of him, or herself, or the patient, and accepts its terms.

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Patient and/or Guardian Initials

HealthCare Surrogate Designation:

In the event I am unable to make medical decisions because of an illness that would prevent me from doing so, I designate the following person to make such decisions on my behalf:

Name: ____
Relationship:______________________________
Address:_________________________________
City:________________________ State: _________ Zip:_____________
Home Phone:________________________ Cell Phone:_____________________

___________________________________ ________________________ _____________
Patient and/or Guardian Signature **Patient and/or Guardian** **Date**