MOBILE MED

PATIENT REGISTRATION FORM

DATE:____/_____/_____

Social Security Number_____-____-_____

Date of Birth____/_____/_____

First Name_____

Middle Initial_____

Last Name_____

Male ☐ Female ☐

Single ☐ Married ☐

Divorced ☐ Widowed ☐

Separated ☐

Address_____

City_____

State/Zip_____

E-Mail_____

Primary Phone_____-_____-_____

Employer_____

Employer Address_____

City_____ State/Zip_____/_____

Employer Phone_____-_____-_____

Black ☐ White ☐

American Indian/Alaska Native ☐

Hispanic/Latino ☐

Asian Pacific American ☐

Asian ☐

Other ☐

Primary Care Physician_____

Pharmacy Name_____ Pharmacy Phone____-_____-_____

Pharmacy Address_____ City_____ State/Zip_____

Emergency Contact_____ Phone_____-_____-_____

Relationship to Patient_____

☐ I authorize Mobile Med, LLC to discuss with the above named contact any medical issues related to my care.

INSURANCE INFORMATION

Insurance Company_____ Member ID #_____

Plan Name_____ State_____ Group ID #_____

Insured (if other than patient)_____

Relationship to Patient _____

Insured's Date of Birth_____/_____/_____ Phone_____-_____-_____

Insured's Employer_____ City/State_____

Employer Phone_____-_____-_____

MOBILE MED PATIENT CONSENT AND AUTHORIZATION

1. Consent to Medical Care and Treatment

While under the care of Mobile Med, I consent to all medical and surgical care, examination and tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me I will not hold Mobile Med, or any individual affiliated with Mobile Med, responsible for any consequences.

2. Release of Information

Our Notice of Privacy Practices provided to you includes information about how we may use & disclose protected health information about you. This notice contains a Your Rights section describing your rights under the law. You have the right to review our Notice before signing this consent and authorization. The terms of our Notice many change. If we change our Notice you may obtain a revised copy by contacting us.

3. Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received or been offered a copy of Mobile Med's Notice of Privacy Practices and I have had a chance to object to the use of or disclosure of my information.

4. Financial Responsibility

I understand and agree that I am financially responsible for payment of all charges incurred. I agree to pay Mobile Med for charges incurred, including incidentals. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurances or payers. I understand that Mobile Med providers are not contracted with insurance plans and makes no guarantee that receipts submitted by you will be reimbursed by your insurance company.

Patient Name_____ Patient Date of Birth:____/____/____

_____ Today's Date:____/____/____

Signature of Patient, Parent, Guardian, or Personal Representative