Suncoast Internal Medicine Consultants
Patient Registration

Name_____

Preferred Name_____

Primary Phone Number_____Secondary Number_____

Address_____

City_____State_____ Zip Code_____

Secondary Address_____

Date of Birth_____Last Four of Social Security Number_____

Marital Status: S M D W Sex: M F Ethnicity: Hispanic or Non Hispanic

Race: American Indian Asian Black Caucasian Pacific Islander Other Prefer Not to Answer

Primary Language_____ Email_____@_____

Employer_____Phone_____

Emergency Contact Name_____Relationship_____

Emergency Contact Phone_____

Referring Physician_____

Pharmacy Name_____Phone_____

Address_____

Insurance Name_____Policy Holder Name_____

Account Number_____Group Number_____

Secondary Insurance Name_____Policy Holders Name_____

Account Number_____Group Number_____

Cancellation/No Show Policy

In consideration of other patients and staff, No Shows and Same Day Cancellations are susceptible to a $50 fee. Cancellations are to be made 24 hours prior to scheduled appointment time.

Assignment of Benefits

I request that payments of any and all authorized insurance benefits be made on my behalf to Suncoast Internal Medicine Consultants for any service or equipment provided to me by the organization.

Responsibility

I understand that it is my responsibility to inform this office immediately of any change in my insurance coverage. I am financially responsible for all fees incurred on my behalf for any service furnished. I am responsible for any balance, Co-Payment, and/or deductible not covered by my insurance. I further agree to pay any fees incurred in the collection of any delinquent charges that I am financially responsible for.

Release of Medical Information

I authorize Suncoast Internal Medicine Consultants to release information concerning my medical care to the Health Care Administration and its agents, and any information needed to determine benefits payable for related services.

Residents and Interns

I understand that Suncoast Internal Medicine Consultants is a teaching facility. Residents, interns and fellows may participate, under the supervision of an attending physician, in my care as part of the Suncoast Internal Medicine education program.

Medicare Recipients Only

I certify the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf of Suncoast Internal Medicine Consultants for any services furnished to me by any physician. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

Privacy Practices

I have been made aware of Suncoast Internal Medicine Consultants Notice of Privacy Practice and that I have a right to receive a copy upon request. This notice describes the types of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Suncoast Internal Medicine Consultants health care operations. I understand that copies of the Notice of Privacy Practices are available in the lobby of the clinic and on the web site SUNCOASTINTERNALMEDICINE.com.

X_____

Signature of Patient or Personal Representative

DATE_____

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Description of Personal Representative's Authority