PATIENT REGISTRATION FORM
DISCLOSURE & CONSENTS

Patient Name: _____ Date of Birth: _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorized direct payment of my insurance benefits to Mitchell County Pediatrics and Health Center or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Mitchell County Pediatrics and Health Center is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me and applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my or my dependents, authorize benefits be made directly to Mitchell County Pediatrics and Health Center or the physician on my behalf.

AUTHORIZATION TO RELEASE, NONPUBLIC, PERSONAL INFORMATION:
I certify that I have received and read a copy of the Mitchell County Pediatrics and Health Center Patient Information Privacy Policy. I hereby authorize Mitchell County Pediatrics and Health Center or the physician individually to release any of my or my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:
I certify that I understand the privacy risk of the mail, phone calls, and e-mail I hereby authorize Mitchell County Pediatrics and Health Center representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment, reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization anytime by notifying Mitchell County Pediatrics and Health Center to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes the lab, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Mitchell County Pediatrics and Health Center physician or his or her designee.

PATIENT SIGNATURE:_____ **DATE:**_____

GUARANTOR SIGNATURE:_____ **DATE:**_____

GUARANTOR NAME (Please Print):_____