DYNASTY PHLEBOTOMY SERVICES LLC

WHERE YOUR TIME AND LABS ARE VALUABLE

2500 Garden Street
Titusville, FL 32796
PHONE: (321) 458-5066

# PATIENT REGISTRATION FORM

*ALL INFORMATION WILL REMAIN CONFIDENTIAL. PLEASE PRINT CLEARLY.*

***Please Have Your ID & Insurance Cards Ready.***

Name: _____ _____ _____
*First* *Last* *MI*

Address: _____ _____ _____
*Address Line 1* *City, State* *ZIP*

Phone Number: _____ E-Mail: _____

Date of Birth: ___/___/_____ Social Security #: _____

Height: _____ Weight: _____

Gender: ☐ *Male* ☐ *Female*

**Are you allergic to Latex?** ☐ ***Yes*** ☐ ***No***

**Have you been fasting for atleast 8-12 hours today? (*water only*)** ☐ ***Yes*** ☐ ***No***

Will you be using insurance for today's visit? ☐ *Yes* ☐ *No*

How did you hear about us?:

☐ Physician's Office Name of practice: _____

☐ Online Search (Google, Bing, etc.)

☐ Facebook

☐ Yelp

☐ Word of Mouth

☐ Pamphlet/Brochure/Flyer

☐ Google Maps

☐ Other: _____

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## Permission For Treatment

I voluntarily consent to any and all specimen collection and diagnostic procedures/testing provided by Dynasty Phlebotomy Services, LLC and its associated clinicians, laboratories, third-party vendors and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the collections, procedures or testing performed by Dynasty Phlebotomy Services, LLC or it's affiliates.

Signature_____ Date:_____

## Authorization & Assignment

I hereby authorize the laboratory, Vista Clinical Diagnostics, Inc., to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment directly to Vista Clinical Diagnostics, Inc. for medical/diagnostic/surgical benefits payable for the services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I understand that I am responsible for all charges incurred regardless of insurance status. I understand that I am responsible for any charges incurred for any returned checks.

I understand that should I have Blue Cross Blue Shield Federal insurance coverage, I may receive a check from my insurance company to cover the services rendered by Vista and, in that event, I agree to forward the check to Vista Clinical Diagnostics at 3705 S. Hwy 27 Ste. 102 Clermont, FL 34711 immediately.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature_____ Date:_____

## Designated Relative

I authorize discussion/release of my general medical condition, laboratory results and diagnosis (including treatment, payment and health care operations) with (_) Spouse (_) Child(ren) (_) Other _____.

Please list the family members or significant others, if any, who we may inform about your medical condition, in case of an emergency:

Name:_____ Phone Number: _____ Email: _____

Name: _____ Phone Number: _____ Email: _____

Signature: _____ Date:_____

## Privacy Notice

I understand that I have the right to request & review a copy of the privacy notice as required by HIPAA.

Signature: _____ Date: _____

Patient Name (Print): _____ Last 4 of SS# _____

Witness: _____ Date: _____

## Medical Records/Result Requests

I understand that by providing my email address on the registration documents, my results may be delivered via electronic format (e-mail) to either myself and/or the designated relative(s) I have assigned above, I am aware of and accept any and all risks associated with electronic transmission of my health information to include, but not limited to, transmission via unencrypted email. I understand that the laboratory will only send the results to the verified email address(es) on file from my patient registration form(s). My results may also be accessible via the laboratory's online patient portal.

Signature: _____ Date: _____