# Lakeshore Family Practice

2308 Homer Clayton Drive Guntersville, AL 35976 Phone 256-582-2581 Fax 256-582-7799
Stephen B Henderson MD Nancy G Seaman CRNP

## PATIENT REGISTRATION

Last Name _____ First Name _____ M.I. _____
Mailing Address: _____ Apt # _____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Preferred Number: ☐ Home ☐ Cell ☐ Work Email Address: _____
DOB: _____ SSN: _____ Marital Status: _____ Gender: _____
Employer: _____ Address: _____
Occupation: _____ Preferred Language: _____
Race: ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Emergency Contact: _____ Relation: _____ Phone #: _____

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Responsible Party – If the patient is a minor, the parent or guardian bringing the patient in will be listed as the guarantor
Name: _____ DOB: _____ SSN: _____
Address: _____
Phone: _____ Relation to Patient: _____

PRIMARY MEDICAL INSURANCE

Insurance Name: _____
Contract # _____ Group # _____ Co-pay _____
Name of Insured _____ Relation to Patient: _____
Gender: _____ DOB: _____ SSN: _____

SECONDARY MEDICAL INSURANCE

Insurance Name: _____
Contract # _____ Group # _____ Copay _____
Name of Insured _____ Relation to Patient _____
Gender: _____ DOB: _____ SSN: _____

I understand that I am fully responsible for all charges incurred during care and treatment, regardless of any insurance benefits I may have. I understand that my insurance company may not reimburse all charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State/Federal law. As the patient and/or Guarantor, I understand that if my account balance remains unpaid for a period of 90 days that Lakeshore Family Practice retains the right to institute whatever method necessary to collect the unpaid balance. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency. I authorize the release of any medical information necessary to facilitate processing my insurance claims. I hereby assign all insurance benefits provided by my insurance company directly to Lakeshore Family Practice. I certify that the information I have reported with regard to the patient's insurance coverage is correct.

Patient Signature _____ Date _____

Responsible Party Signature (if minor): _____ Date _____

Printed Name of Responsible Party _____ Relation to Patient _____

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A. Consent to Treatment

I authorize the providers at Lakeshore Family Practice and other healthcare providers under the direction of the physician to provide reasonable and proper medical care by today's standards. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

_____
Initials

B. Notice of Privacy Practices

I, _____, was provided a copy of Lakeshore Family Practice's Notice of Privacy Practices. Lakeshore Family Practice may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Lakeshore Family Practice to use or disclose my PHI in conjunction with Lakeshore Family Practice's treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature of Patient/Guardian Date

C. Communication Consent

I hereby authorize and give my consent to Lakeshore Family Practice to leave messages on my answering machine/voicemail for the following (check all that apply)

□ Appointment Reminders □ Prescription Refills □ Medical Information □ Test Results
□ Insurance/Payment Issues □ Mail

I further authorize and give consent to Lakeshore Family Practice to communicate any of my PHI to the following person/persons:

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |

_____ _____
Signature of Patient/Guardian Date