Franciscan PHYSICIAN NETWORK

REGISTRATION FORM

Date: ______________

Patient Name: ____ Sex: ☐ F ☐ M
Last First Middle

Social Security #: ______________________ Birth Date: ______________________

Address: ______________________ ______________________
Street/Apt # City / State / Zip Code

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ______________________ Language: ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(ed) Ethnicity: ________ Religion: ________ Race: ________

Primary Care Physician: ______________________ Referring Physician: ______________

Preferred Pharmacy Name & Phone: ______________________________

Employer/School: ______________________ Occupation ______________

Address: ______________________ ______________________
Street/Apt # City / State / Zip Code

Phone: ______________________ Fax: ______________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

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Spouse's Name: ______________ Employer: ______________ Work Phone: ______________

Address: ____

Phone: ______________ Work Phone: ______________ Mobile Phone: ______________

If patient is a minor, parent/legal guardian is: ______________ Relationship to patient: ______________

Emergency Contact ______________________ Relationship to Patient ______________

Emergency Contact Home Phone ______________________ Cell Phone ______________

WHO SHOULD RECEIVE THE BILL

Name: ______________ Relationship to Patient: ______________ Sex: ☐ F ☐ M

Social Security #: ______________ Birth Date: ______________ Phone: ______________

Address: ____

Employer: ______________________ Work Phone: ______________

Employer Address: ____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

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MEDICAL INSURANCE INFORMATION

First (Primary) Insurance Co.: ____

Insurance Co. Address: ____

Policy Holder's Name: ______________________ Relationship to Patient: ______________

Policy Holder's Birth Date: ______________ ID: ______________ Group/Policy #: ______________

Policy Holder's Employer: ______________________ Social Security #: ______________

Effective Date: ______________

Secondary Insurance Co.: ____

Insurance Co. Address: ____

Policy Holder's Name: ______________________ Relationship to Patient: ______________

Policy Holder's Birth Date: ______________ ID: ______________ Group/Policy #: ______________

Policy Holder's Employer: ______________________ Social Security #: ______________

Effective Date: ______________

1. GENERAL CONSENT TO MEDICAL TREATMENT

I hereby request and consent Franciscan Physician Network (this practice) and their employees and agents ("Provider") to attend me during my treatment and perform routine tests and procedures and to provide certain health care services as prescribed for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by Provider, nor have I relied upon any such representations, warranties, or guarantees. I understand that physicians who hold limited licenses to practice medicine and are currently in residency programs and/or other health career students may assist with my care and treatment, within the scope and limitation of the applicable health education program, during my office visit. Resident physicians and other students of health care will be supervised by instructors or office staff.

2. TELEHEALTH

We are providing this information on behalf of the Healthcare Providers: Your clinic visit may be conducted through a Telehealth visit. Telehealth Visit involves the use of electronic communications to enable health care providers at sites remote from patients to provide consultative services. The information obtained in this visit may be used for diagnosis, therapy, follow-up and/or education, including live two-way audio and video and other materials (e.g. medical records, data from medical devices).

The communications systems used will incorporate network and software security protocols to protect the confidentiality of patient information and will include reasonable measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

A visit summary will be provided to you after each visit which may be kept for your records and may be shared with your local primary care or other provider, as appropriate.

Anticipated Benefits of Telemedicine:

- Improved access to care may enable a patient to remain at his or her home, office or remote site while consulting with a clinician.
- More efficient medical evaluation and management.

Possible Risks of telemedicine:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks may include, without limitation, the following:

- Security protocols could fail, causing a breach of privacy of personal medical information

By agreeing to these Terms of Use for a Telemedicine visit, you acknowledge that you understand and agree with the following:

a) The laws that protect privacy and the confidentiality of medical information also apply to telemedicine.
b) Telemedicine may involve electronic communication of your personal medical information to health service providers who may be located in other areas, including out of state providers.

3. CONSENT TO PHOTOGRAPH

I understand photos and/or video may be taken during the course of or in connection with my visit and/or the care and treatment I receive. I consent to those photos and/or video to be taken and for them to be part of my medical record. I also consent to my photograph being taken and used for identification.

4. MyChart ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT

If available, I hereby request access to MyChart and understand that in order to gain access to MyChart I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of MyChart is subject to certain terms and conditions. I agree to review MyChart terms and conditions before accessing MyChart and further agree that by accessing MyChart I am agreeing to abide by the MyChart terms and conditions. To gain proxy access for children less than 18, a separate MyChart proxy access form will be used.

Initial here if you are declining electronic access to your medical record: ______

5. FINANCIAL AGREEMENT

I hereby agree to pay Provider their charges for all services rendered during my treatment. **I acknowledge Franciscan Physician Network is required under arrangements with insurance companies to collect my portion of fees at the time of service. I acknowledge and agree that my co-payment or deductible is fully due and payable to Franciscan Physician Network along with any self-pay fees or balances at the time of service. Accordingly, I further acknowledge a minimum payment of $75 is due for any self-pay fees or balances as a deposit towards my services.** I shall also be responsible for any attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to Provider payment to any health insurance benefits, including but not limited to any and all applicable Medicare and Medigap benefits, applicable to this treatment and authorize the release of information necessary to determine coverage and to permit reimbursement on my behalf to Provider. Such payments, however, shall not exceed my balance owed to Provider. I hereby certify that any information which I have given in applying for coverage under Title XVII and/or Title XIX of the Social Security Act, or any insurance or other information which I provided is true and correct. Some of these individuals may not participate in the same insurance plans as the hospital. You may have greater out-of-pocket costs for services provided by out-of-network providers. You should contact your health care plan for questions concerning coverage or benefit levels and for subscriber's certificate of coverage. (__________) Initial.

6. TELEPHONE/CELL PHONE NUMBER

In order to contact me related to my healthcare and financial arrangements, I authorize Franciscan Alliance, Inc. and its designees to utilize any and all of my contact information (including my email and cell phone) provided to Franciscan Alliance, Inc., or any of its divisions, and utilizing various methods including automated calling, texting and the use of pre-recorded messages.

7. REVOCATION OF CONSENT

I may revoke this consent at any time except to the extent that any Franciscan Physician Network practice has already taken action in reliance on it.

8. INDIANA LAW AND JURISDICTION

I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by Franciscan Physician Network.

______________________________ Patient Printed Name

__________ Date

___/___/___ Patient Date of Birth

______________________________ Patient Signature

__________ Date

______________________________ Patient's Legal Guardian or Responsible Party Signature (if applicable)

__________ Date

______________________________ Witness

__________ Date

Patient last 4 of Social Security Number: ______________

HIPAA NOTICE OF PRIVACY PRACTICES – Acknowledgement Form

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES

Acknowledgement Form

By signing below, I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices ("Notices"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at franciscanalliance.org

Name of Patient	Date of birth
Patient or Legal Guardian Signature	Date
Witness Signature	Date

Reason Given by Patient if Refusing to Sign this Notice

Recorder's Signature

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

HIPAA Notice of Privacy

212-031 Rev 02/20/19

HIPAA Privacy File Acute

Please
bring ID

ἑ insurance
card

or copy of
insurance