HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.
https://www.providence.org/utility-pages/notice-of-privacy-practices

______________________________ ______________________________
Patient Name (Print) Date of Birth

______________________________ ______________________________
Patient /Representative Signature Relationship to Patient Date

You may share information about my condition with:

____

____

REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION

You may request to receive confidential communications involving your protected health information (PHI) by an alternative means or at alternative addresses. We may not ask you the reason for your request. We will accommodate all reasonable requests. If you make a special request, you must give us an alternative address or other method of contacting you (phone number etc,). Please specify how or where you wish to be contacted:

☐ Leave a detailed message on Answering Machine #: ______________________

☐ Send communication via fax #: ______________________

Signature of patient or representative: ______________________

Relationship to patient ______________________ Date: ____________

Witness: ______________________ Date: ____________

Providence Mission Heritage Medical Group
Providence St. Joseph Heritage Medical Group
Providence St. Jude Heritage Medical Group
Providence St. Mary High Desert Medical Group

NOTICE OF PRIVACY PRACTICE ACK – SO CAL

Patient Name: ______________________

MRN: ______________________

Date: ______________________

AVISO SOBRE PRÁCTICAS PARA MANTENER LA INFORMACIÓN CONFIDENCIAL

Los reglamentos de HIPAA ("Health Insurance Portability and Accountability Act", en español: Acta de Responsabilidad y Traslado) requieren que le proporcionemos a usted, el paciente, o a su representante personal, una copia de nuestro Aviso Sobre Practicas Para Mantener la Información Confidencial y que usted acuse recibo del folleto por medio de su firma.
https://www.providence.org/utility-pages/notice-of-privacy-practices

______________________________	______________________________
Nombre del Paciente	Fecha de Nacimiento
______________________________	______________________________
Firma del Paciente/Representante	Relación con el Paciente Fecha

Ustedes pueden proporcionar información acerca de mi estado de salud a:

____

____

SOLICITUD PARA MEDIOS DE COMUNICACION ALTERNOS

Usted puede solicitar que la información protegida y confidencial acerca de su salud (PHI por sus siglas en inglés) se la envíen por medios privados alternos o a un domicilio diferente. Probablemente no le preguntemos el motivo de su solicitud. Daremos curso a todas las solicitudes razonables. Si hace una solicitud especial, debe proporcionarnos un domicilio alterno u otro método para comunicarnos con usted (número de teléfono, etc.) Por favor especifique el modo en que desea que nos comuniquemos con usted:

☐ Dejar un mensaje detallado en el contestador autoático #: ______________________

☐ Enviar comunicación a través fax # ______________________________

Firma del paciente o representante: ______________________________

Relación con el paciente: ______________________ Fecha: ______________

Testigo: ______________________________ Fecha: ______________

Providence Mission Heritage Medical Group
Providence St. Joseph Heritage Medical Group
Providence St. Jude Heritage Medical Group
Providence St. Mary High Desert Medical Group

NOTICE OF PRIVACY PRACTICE ACK – SO CAL - SPANISH

Patient Name: ______________________

MRN: ______________________

Date: ______________________

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MRN: ______________________________

Date: ______________________________

Providence
Medical Foundation

REGISTRATION FORM

PATIENT INFORMATION

Patient Legal Name: ____
Last Legal First Middle

AKA: ____

Date of Birth: ____________________ Sex: __________ Driver's Lic #: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Last 4 digits of Social Security #: __________________ Ethnicity: ________________ Race: ________________

Mailing Address: ____

City: ______________________________________ State: __________ Zip: ______________

I'd like to receive appointment and clinical reminders via text. ☐ Yes ☐ No Cell # ______________

Preferred Telephone # for Routine Communication: ______________________ ☐ Home ☐ Work ☐ Cell

Secondary Phone: ______________________________________ ☐ Home ☐ Work ☐ Cell

E-mail: ______________________________ Primary Spoken Language: ____________________

Primary Care Provider: ______________________ How were you referred?: ____________________

Employer: ____________________________________ Employer Phone #: ________________

Work Address: ____________________________ City: ______________ State: ______ Zip: ________

EMERGENCY CONTACT

If patient is a child, please provide an emergency contact other than a parent/guardian.

Contact Name: ____________________________________ Relation to Patient: ______________

Address (Street or P.O.B.) ____

City: ______________________________________ State: __________ Zip: ______________

Home Phone: (____) ______________ Work Phone:(____) ______________ Cell Phone:(____) ______________

PRIMARY RESPONSIBLE PARTY

☐ I am responsible party ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ________________

Name: ____
Last First Middle

Date of Birth: __________________________________ Sex: __________

Street Address: ____

City: ______________________________________ State: __________ Zip: ______________

Phone: ____________________________________ Driver's Lic #: ______________________

Employer: ____________________________________ Employer Phone #: ________________

Work Address: ____________________________ City: ______________ State: ______ Zip: ________

SECONDARY RESPONSIBLE PARTY

Name: ______________________________ ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ______________

Employer: ____________________________________ Employer Phone #: ________________

Work Address: ____________________________ City: ______________ State: ______ Zip: ________

Providence Medical Foundation

MRN:______________________

INSURANCE INFORMATION

Primary Insurance Company Name ____

Subscriber's Name ____________________________Date of Birth___/___/_____

Relation to patient________________________

Subscriber's address if other than patient ____

Secondary Insurance Company Name ____

Subscriber's Name ____________________________Date of Birth___/___/_____

Relation to patient________________________

Subscriber's address if other than patient:____

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen a Providence Medical Foundation affiliated medical group to provide healthcare services. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature________________________________ Date ____/____/____

COMMUNICATION CONSENT

By providing the Providence Medical Foundation or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that Providence Medical Foundation or its service providers may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that Providence Medical Foundation and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services .

☐ Initials / Approve ☐ Initials / Decline

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to Providence Medical Foundation for services provided to me by a Providence Medical Foundation affiliated medical group. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

____ ____/____/____

Signature of Patient (If minor, signature of responsible party) Date

____ ____/____/____

Print Patient Name Patient Date of Birth

AUTHORIZATION FOR TREATMENT: I authorize the Provider(s) or his/her designee(s), in charge of my or the patient's care to administer any treatment including medication(s) or vaccine(s) as deemed necessary or advisable in the diagnosis and treatment of any conditions related to me or the patient. I authorize the Physician(s) or their designee(s), in charge of my or the patient's care to use communications technology-based services ("CTBS") for treatment and billing of care or consultation with other professionals about the care of the patient. This authorization is valid and in effect until such time I withdraw it in writing or in person.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS

MEDICARE/MEDICAID AND OTHER GOVERNMENT PROGRAMS: If I qualify for benefits under Medicare, Medicaid, or any other government program, I authorize these program(s) to make payment directly to Providence for my care. I also authorize Providence to release all relevant information about me and my health care necessary to receive payment to the applicable government program(s). I am responsible for paying my deductible and/or co-insurance under such program(s).

INSURANCE: If I qualify for benefits from any insurance company(s), I assign those benefits to Providence to pay for care provided. I also authorize Providence to release all relevant information about me and my health care to the company(s) necessary to receive payment. I am responsible to pay any co-payments and/or deductible required under your insurance plan(s). I understand, to check with my insurance to confirm my coverage and anticipated out-of-pocket costs.

PAYMENT TERMS: Providence has agreed to accept assignment of benefits from governmental health care programs and certain insurance companies. I remain personally responsible for payment in full for billed charges, unless otherwise required by law.

EXPRESS CARE CLINIC LOCATIONS: Providence Express Care services are set at a basic low rate. Providence's usual discount policy does not apply to Express Care services.

FINANCIAL ASSISTANCE: If I am unable to meet the financial requirements for the services rendered, I am aware that I may apply for financial assistance or establish a payment plan by contacting a Providence financial representative.

If you have questions or would like to receive a financial assistance application form, please contact below:

By telephone: 1-866-747-2455 **On our website at:** www.providence.org

RIGHT TO REVOKE AUTHORIZATION: I have the right to cancel my assignment or my authorization for Providence to release information about me and my health to government programs and insurance company(s). My revocation must be in writing and will be effective when it is received by Providence.

USE AND DISCLOSURE OF INFORMATION: The manner in which Providence may use information about me is explained in the" Notice of Privacy Practices."

PHOTOGRAPHS: I agree to allow Providence to take, reproduce and use photos, video tape, video monitoring / recording, or audio recording for the purpose of diagnosis, testing, medical evaluation, care or treatment (including invasive procedures), patient safety or medical education, and to preserve clinical information. I understand that this material may be treated as a part of my medical record and that Providence privacy policies apply.

PATIENT LABEL

Consent: Authorization for Treatment and Financial Responsibilities

FINANCIAL RESPONSIBILITY STATEMENT: I accept financial responsibility for all treatment provided. The balance is due 30 days from the date of billing. If I need financial assistance or wish to establish a payment plan, I can contact a Providence financial representative. Should this account be assigned to an attorney or collection agency, I will be obligated to pay associated costs. I request direct payment of benefits to Providence for any clinical services rendered.

- I understand Providence will make inquiries regarding insurance coverage and my financial responsibility from third party payors or financial references. In addition, I approve these payors and/or references to release information to Providence.
- I understand Providence will comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation or gender identity.
- I have read, or have had explained to me, the above Authorization for Treatment and Financial Responsibility Statement. I understand the contents and by signing; I agree to be legally bound by this document.
- By signing this document via electronic signature pad, I certify that I am of lawful age and legally competent to consent.

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent those methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

Patient's Full Name: ______________________________

Signature: ______________________________ Date: ____________ Time: ________ A.M. / P.M
(Patient/Legal Representative)

Relationship to Patient: ______________________________ (If consent is not signed by the patient)

Name of interpreter: ______________________________ (If used to explain document to patient)

Print Witness Name: ______________________________

Witness Signature: ______________________________ Date: ______________________

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PATIENT LABEL

Consent: Authorization for Treatment and Financial Responsibilities

CHART/White • PATIENT/Yellow