Medical Associates of Brownsville
at SPRINGMAN MEDICAL PLAZA

REGISTRATION FORM

Today's Date:			**PCP:**		
PATIENT INFORMATION					
Patient's last name: **First:**			**Middle:**	**Marital status:** M D W S	
Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**Former name:**	**Birth date:**	**Age:**	**Sex:** M F
Address: **City,** **State** **Zip Code**					
Email Address:					
Security no.:	**Home phone no.:**		**Cell phone no.:**		
Language: English Spanish Other	**Ethnicity:** Latin/Hispanic Not Hispanic Refuse to Answer		**Race:** White Hispanic Asian Black/African American		
Occupation:	**Employer:**		**Employer phone no.:**		
Name(s) of other Physicians who care for you:					
Pharmacy:					
INSURANCE INFORMATION					
Person responsible for bill:	**Birth date:**	**Address (if different):**		**Home phone no.:**	
Occupation:	**Employer:**	**Employer address:**		**Employer phone no.:**	
Please indicate primary insurance:					
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment:** $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		**Subscriber's name:**		**Group no.:**	**Policy no.:**
Patient's relationship to subscriber: |					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		**Relationship to patient:**	**Home phone no.:**	**Work phone no.:**	

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The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient/Guardian signature **Date**

PATIENT DISCLOSURES & CONSENTS

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

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of medical benefits, otherwise payable to me, to Medical Associates of Brownsville for all the services they provide. I understand that I am financially responsible to Medical Associates of Brownsville for charges not covered by this assignment. I authorize Medical Associates of Brownsville release to my insurance company any medical information for processing of a claim. I authorize Medical Associates of Brownsville to obtain information pertaining to my insurance coverage and benefits from the carrier of same. I permit a copy of this authorization to be used in place of the original.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZTION AND INFORMATION RELEASE:

I request that payment of authorized medical benefits be made either to me or on my behalf to Medical Associates of Brownsville for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and noncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of Medical Associates of Brownsville's Patient Information Privacy Policy. I hereby authorize Medical Associates of Brownsville to release any of my, or my dependent's, 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 risks of the mail, phone calls, and/or e-mails. I hereby authorize a Medical Associates of Brownsville/S.P.I. Clinic/R.G.V. Day & Night Clinic representative to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand I have the right to rescind this authorization at any time by notifying the facility of such in writing. Please indicate your preferred method of communication by circling below:

Home/Cell Phone	**Work**	**Written Correspondence**
Leave Call Back Number Only	Leave Call Back Number Only	By Mail
Leave Detailed Message with: _____	Leave Detailed Message with: _____	By Fax: _____
Leave Detailed Message on Answering Machine/Voice Mail	Leave Detailed Message on Answering Machine/Voice Mail	Send to Personal Email

LAB/RADIOLOGY/DIAGNOSTIC SERVICES:

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I understand that I may receive a separate bill if my medical care includes lab, radiology, 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 my physician or his/her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

GUARANTOR NAME (please print): _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I authorize Medical Associates of Brownsville/S.P.I. Clinic/R.G.V. Day & Night Clinic to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENTIMIENTO PARA OBTENER HISTORIAL EXTERNO DE MIS RECETAS MEDICAS:

Yo autorizo a las clínicas Medical Associates of Brownsville/S.P.I. Clínic y R.G.V. obtener acceso total sobre el historial de mis recetas médicas externas vía el servicio de internet RxHub. Igual comprendo y consiento que mi historial de recetas medicas podrá ser analizada por múltiples proveedores médicos con y sin afiliación, personal médico, distintos abastecedores, y compañías de seguros. Esto puede incluir prescribes antiguas y vigentes.

MI FIRMA CERTIFICA QUE LEI Y ENTENDI EL ALCANCE DE MI CONSENTIMIENTO Y QUE AUTORIZO EL ACCESO.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

GUARANTOR NAME (please print): _____