North Shore Medical Center Account Registration

PATIENT INFORMATION (PLEASE PRINT)

Date of Birth __________________________ Gender □ Male □ Female SSN ______-________-______

Full Name (Last, First, MI) ____

Mailing Address ____

Home Address ____

Home Phone ____________________ Cell Phone ____________________ Work Phone ___________________

Employer ____

Email ____

Marital Status □ Single □ Married □ Partnership □ Widowed □ Legally Separated □ Other

SPOUSE, PARENT, GUARDIAN INFORMATION (Required if patient is NOT Subscriber and/or NOT responsible for their own bills.)

Full Name (Last, First, MI) ____

Relationship to Patient □ Parent □ Spouse □ Guardian □ Other SSN ______-________-______

Mailing Address ____

Home Address ____

Home Phone ____________________ Cell Phone ____________________ Work Phone ___________________

Employer ____________________________ Date of Birth ________________ Gender □ Male □ Female

NOTICE OF RECEIPT OF INFORMATION

I have read and I understand the following information provided by the North Shore Medical Center regarding my participation in health care: (please initial)

_____ HIPAA Notice of Privacy Practices

_____ North Shore Medical Center Provider Policies

_____ TCS(Transactions on Computer Systems)

Do we have permission to:

Leave a message on your answering machine at home? □ Yes □ No

Leave a message on your cell phone's voice mail? □ Yes □ No

Discuss your medical condition with a member of your household? □ Yes □ No

Name of representative __________________________________ Relationship __________________

This section will be completed if the written acknowledgement of receipt is not obtained:

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

_____ The individual refuses to sign or otherwise fails to provide an acknowledgement

_____ The individual was mailed a copy of the Notices and did not mail back his or her receipt of acknowledgement.

_____ Other ____

EMERGENCY CONTACT

Name ______________________________________ Relationship to patient ___________________________

Home Phone ____________________ Cell Phone __________________ Work Phone ___________________

As a patient you have certain responsibilities for your care. These responsibilities include:

□ Providing current accurate billing information at all visits, □ Provide physician with complete medical history, □ Being aware of the coverage provided by your insurance company.

I hereby authorize my insurance benefits to be paid directly to my attending physician's corporation and I am financially responsible for the balance due. I authorize North Shore Medical Center, LLC, and it's attending physicians, to release any information necessary to process an insurance claim.

My signature acknowledges understanding and consent to all of the above information.

Signature ______________________________Printed ______________________ Date ___________________