Liberty Doctors

Patient Registration Form

PATIENT INFORMATION

Preferred Pharmacy	*Local pharmacy. This will be used to electronically send your prescriptions when possible.		In order to have access to your Medication History, Liberty Doctors needs your authorization. (PBM consent) Yes □ No □		
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
E-Mail		Date of Birth		Sex	M F
Marital Status	S M D W SEP	SSN		Race	
Preferred Language		Ethnicity			

RESPONSIBLE PARTY INFORMATION (if other than patient)

Relationship to Patient		*This area to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian, etc…)			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
Date of Birth		SSN		Sex	M F

PRIMARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

SECONDARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

Emergency Contact Name		Phone #	
Patient/Legal Guardian Signature		**Date**	
Liberty Doctors Employee Witness Signature		**Date**	

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Liberty Doctors (**LD**) to meet your medical needs. We are dedicated to providing the best treatment available. **Carefully read and initial each section and sign and date the bottom**.

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by LD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as to the results of treatments or examinations at LD.

Initials_______________

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize LD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to LD. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for LD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize LD to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review LD Notice of Privacy Practices in the office upon request.
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Initials________________