PATIENT REGISTRATION

Updated Yearly

PATIENT INFORMATION:

NAME: ____

ADDRESS: ____

CITY: ____________________________________ STATE: _______ ZIP:__________________

DOB: _____________ SS #:___________________ SEX: M F HOME #:_____________________

E-MAIL ADDRESS: ____________________________________ Cell #: _____________________
(By providing your email address you are consenting to Liberty Medical Center staff to use it to send you lab results, and other correspondence regarding your medical care, etc. and realize that emails are not 100% secure.)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER: ____

ADDRESS: ____

CITY: ______________________________ STATE: _______ ZIP:___________

WORK #:________________

PERSON RESPONSIBLE FOR BILL:

NAME: ____

ADDRESS: ____

CITY: ____________________________________ STATE: _______ ZIP:__________________

DOB: _____________ S S #:___________________ SEX: M F HOME #:_____________________

WORK #: _____________________ RELATIONSHIP TO PATIENT: ____________________________

RESPONSIBLE PARTY EMPLOYER: ____________________________________

EMPLOYER PHONE #: ____________________________________

EMERGENCY CONTACT:

NAME: ____

ADDRESS: ____

CITY: ____________________________________ STATE: _______ ZIP:__________________

HOME #:_____________________ WORK #:_____________________

INSURANCE INFORMATION:
Insurance card/cards must be given at time of service and at any time it is requested by this office. If at any time your insurance changes, please let us know so the proper insurance is filed in a timely manner. If incorrect information is given, you will be responsible for the entire bill.
ALL CO-PAYS AND INSURANCE DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

I authorize payment of medical benefits to be made directly to Liberty Medical Center.

Signed: ____

Relationship to Patient (If Signed By Guardian): ________________________________ Date:_________________

(TURN OVER)

Liberty Medical Center
1504 NE 96TH STREET
Liberty, MO
816-415-2233

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Obtain payment from third-party payers.

Conduct normal healthcare operation, such as quality assessments and physician certifications.

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

I have been informed by you of your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

We have adopted a policy that requires authorization form the patient to leave a detailed message for that patient. This is to protect the privacy of the patient and to protect the physician and staff of this practice from violating the patient's confidentiality. If there is not a signed consent on file, Dr. Malisos or the staff will only leave their name and telephone number on an answering machine, voicemail, or with a person answering the phone asking the patient to return the call.

By completing the consent below, you are allowing this medical office and its staff to leave a message on an answering machine, email, voicemail, or with a specified individual. You can specify what information is left and with whom. By signing, you are also consenting to the mailing, emailing or faxing of any results requested by you or another physician involved in your care.

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I give my consent to Rodney Malisos, MD and the entire staff of Liberty Medical Center to leave a message regarding scheduling, treatment, surgery, lab, radiology results, or other information as necessary

_____ on answering machine, email or voicemail at home or cell phone.

_____ on answering machine, email or voicemail at work.

_____ With ___________________________ Relationship ___________________________

With ___________________________ Relationship ___________________________

_____ **I DO NOT** consent to messages being left at home, work, or with any other person. I wish to make an individual appointment each and every time I need to be notified by anyone from this office staff for any reason.

_____________________________ _________________

Patient's Name (Please Print) DOB

_____________________________ _________________

Patient's Signature Date

_____________________________ _________________

Witness Date