Patient Legal Name:____
Last First MI

Patient Address:____
Street/PO Box City State Zip

Patient Numbers: Home (   )__________ Cell (   )______________ Work (   )__________

Which number is best to contact you at? Home Cell Work

Patient Date of Birth __/__/____ Age:________ Sex: M/F Marital Status: M / S / D / W SSN :______________

Email: ______________________________Preferred Care Provider:______________________

Pharmacy:______________________________ Pharmacy Location:______________________

EMERGENCY CONTACT

Emergency Contact: ______________________________ DOB: ______________________

Phone #:______________________________ Relationship:______________________

PRIMARY INSURANCE

Insurance Company Name: ______________________________ Subscriber Name:______________________

Relationship:______________ Dateof Birth:______________Social Security #:______________________

SECONDARY INSURANCE

Insurance Company Name: ______________________________ Subscriber Name:______________________

Relationship:______________Date of Birth:______________Social Security #:______________________

FOR MINOR PATIENTS

Mother's Name:______________________ Phone Numbers: Home (   )______________ Cell (   )__________

Address:____
Street/PO Box City State Zip

Father's Name:______________________ Phone Numbers: Home (   )______________ Cell (   )__________

Address:____
Street/PO Box City State Zip

Guardian's Name:______________________ Phone Numbers: Home (   )______________ Cell (   )__________

Address:____
Street/PO Box City State Zip

Assignment of Benefits

I hereby authorize, from this day forward, any insurance company, including Medicare or Medicaid, whom I subscribe with to pay directly to St. Cloud Medical Group charges for services rendered. I understand that I am responsible for all charges made to me and/or my family's account and it is my responsibility to notify the St. Cloud Medical Group of any changes pertaining to my insurance coverage and/or my account.

Financial Agreement

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts. Payments are due upon reciept of the first statement. I understand that all insurance coverage questions should be addressed with my insurance carrier. St. Cloud Medical Group's written financial policy is available on our website or upon request. The undersigned acknowledges receipt of this information.

Advance Directive

I understand that upon request, St. Cloud Medical Group may provide me with an Advance Directive form and information regarding completing an Advance Directive.

______ I HAVE an Advance Directive (Living Will)

______ I DO NOT HAVE an Advance Directive (Living Will)

Privacy Practice Acknowledgement

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in St. Cloud Medical Group's Notice of Privacy Practices. St. Cloud Medical Group is permitted to revise its Notice of Privacy Practices at any time. We will post the current notice at our facility, on our website, and have copies available for distribution. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. The undersigned acknowledges receipt of this information.

A copy of this agreement shall be considered effective and valid as the original.

Release of Information

I irrevocably agree that the facility may disclose, to the extent allowed by the law, my medical and financial record to any affiliate of the facility, specifically including (a) my referring and/or family physician, (b) any physician treating, consulting, or otherwise performing services for me, including his or her employees and agents, (c) insurance companies including Centers for Medicare and Medicaid Services, the Health Care Financing Administration and its agents, if applicable to determine those benefits payable for related services, any other governmental or accrediting agency, or their agents or employees, (d) the responsible party, (e) the person(s) I have listed below, (f) the emergency contact listed above, and (f) myself.

____

NAME RELATIONSHIP PHONE NUMBER

____

NAME RELATIONSHIP PHONE NUMBER

______________________________ ____________________

Signature of Patient/Guarantor Date