Registration Form (please print legibly)

Patient Information

Patient Name: ____ Last / First / Middle		Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐	Marital Status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? YES ☐ NO ☐ ____	If Patient is a minor, your name and relationship?		
Date of Birth: ____ Month/Day/Year	Age:	Sex: M☐ F☐	Race/Ethnicity:
Social Security Number:		Phone Number:	
Street Address and Resort:			
PO Box:	City:	State:	Zip Code:
Occupation:	Primary Insurance:	Email Address:	

How did you find us? (please check one)
Internet Search ☐ Sign ☐ Yelp ☐ Resort/Condo ☐
Facebook ☐ Local Business ☐ Advertisement ☐ Other ____

Have you been seen here in the last 3 years? YES ☐ NO ☐

Payment Information

Name (If different than above): ____ Phone Number: ____

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT

Emergency Contact Information

Name: ____ Home Phone Number: ____
Relationship to Patient: ____ Work/Cell Phone Number: ____

HIPAA Notice

Minit-Medical follows the HIPAA Privacy Rule, which gives individuals a fundamental right to be informed of the privacy practices of their care providers. Health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns. Please ask your health care provider or any other MM Employee if you'd like a copy of our privacy act. I understand and agree that the Minit-Medical HIPAA Privacy Act is available, and I will request a copy if interested.

Please **INITIAL** here if you agree: ____

Medicare Patients

Minit-Medical has legally opted out of Medicare. By signing, you are entering into a private contract, and agree to pay up front for your visit today. Neither the Patient nor Minit-Medical will submit a claim to Medicare.

Please **INITIAL** here if you agree: ____

Designation

The above information is true to the best of my knowledge. I give consent to Minit Medical to access patient Rx history. I authorize any non-par insurance benefits I may receive to be paid directly to myself, not the provider/clinic. I understand that I am financially responsible for any balance. I also authorize Minit-Medical or my insurance company to release any information required to process my claims. I give informed consent to treatment of my presenting condition.

Patient/Guardian Signature: ____ **Date:** ____