Franciscan PHYSICIAN NETWORK

Signature_____Date_____

Primary Care Physician_____

Patient Information

Last Name_____

First Name_____ Middle Initial____

Soc Sec #_____ Sex o M o F

Birth date_____ Age_____

Address_____

City_____

State_____ Zip_____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

Email address _____

Marital status o Single o Married o Widowed o Divorced

Ethnicity o Hispanic o Non-Hispanic o Unknown o I prefer not to answer

Race
o American Indian/Alaskan Native
o Black or African American
o Native American/Other Pacific Islander
o Asian o Other
o White/Caucasian o I prefer not to answer

Religion _____

Patient employed by _____

Employment Status o Full-time o Part-time o Not-employed

Occupation _____

Work address _____

Guarantor/Responsible Party Consenting for Care

Relationship to Patient _____

Last Name_____

First Name_____ Middle Initial____

Address_____

City_____

State_____ Zip_____

Soc Sec #_____ Sex o M o F

Birth date_____ Age_____

Home Phone (_____) _____

Work Phone (_____) _____

Guarantor employed by _____

Employment Status o Full-time o Part-time o Not-employed

Occupation _____

Work address _____

_____

_____

EMERGENCY CONTACT (closest relative or friend not living with you)

Emergency contact _____

Relationship to patient _____

Emergency contact phone number_____

Contact Address _____

City _____ ST _____ Zip_____

Primary Insurance

Relationship to patient_____

Insurance Company_____

Insurance Address_____

City _____ ST _____ Zip _____

Group # _____

Group Name _____ Eff Date _____

Policy # _____

Subscriber Last Name_____

Subscriber First Name_____ MI____

Subscriber's Address_____

City _____ ST _____ Zip _____

Social Security #_____

Birth date _____ Sex o M o F

Subscriber's Phone (_____)_____

Subscriber employed by _____

Secondary Insurance

Relationship to patient_____

Insurance Company_____

Insurance Address_____

City _____ ST _____ Zip _____

Group # _____

Group Name _____ Eff Date _____

Policy # _____

Subscriber Last Name_____

Subscriber First Name_____ MI____

Subscriber's Address_____

City _____ ST _____ Zip _____

Social Security #_____

Birth date _____ Sex o M o F

Subscriber's Phone (_____)_____

Subscriber employed by _____

Franciscan
PHYSICIAN NETWORK

Patient Authorization and Assignment of Benefits

- I hereby authorize and consent to the performing of any medical procedure or treatment/examination and such additional procedures or treatments as are considered necessary by my physician on the basis of his/her findings. I acknowledge that no guarantees, representations or warranties have been made to me regarding the result of treatments, examinations or care at Franciscan Physician Network (FPN). I understand that my physician's office and people who work there will rely on my consent on this form until I cancel it.
- I hereby assign FPN any and all benefits which are due or are to become due to me as a result of medical services rendered on my behalf and authorize such benefits to be paid directly to FPN. This includes payment of authorized Medicare/Medicaid benefits for any items or services furnished to me by FPN. I authorize any holder of medical records or other medical information about me to release such information to determine benefits payable for related services to the Centers for Medicare and Medicaid Services (CMS) and its agents.
- I understand that services not covered by insurance are payable on completed service. If I have insurance (all types, including motor vehicle insurance) and it has not paid I agree to pay any balance due on receipt of statement. I understand that if I provide inaccurate insurance or billing information which results in penalties or the inability of FPN to secure payment from my insurer I will be financially responsible for all charges incurred. I understand that some services have pre-certification requirements and any unpaid balance due for failure to comply with the pre-certification requirements of my insurance company will be my responsibility. I am also responsible for any applicable costs incurred in attempting to collect from my medical insurance or on my account, including attorney fees.
- I understand that FPN may give information in my medical record to any person involved in my medical care. FPN may also obtain information that is needed to treat me from other persons or healthcare facilities that have provided medical care to me. FPN may also give information in my medical record to any third party payer who may be responsible for payment of my account
- I consent to receiving auto-dialed and/or artificial or pre-recorded message calls to my cellular telephone and to any telephone number provided by me from FPN or its affiliates and their agents including without limitation, any account management companies and independent contractors including without limitation any debt collectors.

Patient Name/ID# (PRINT) Receptionist to complete:	I authorize the following individuals to receive information and to be present during treatment/care.
Patient or Legal Representative Signature **X**	Name/Relationship
Relationship to Patient	Name/Relationship
Date	Name/Relationship

Form: F.005 Revised 12/15/2011