TRINITY PROFESSIONAL GROUP
REGISTRATION/CONSENT TO TREAT FORM AND HIPAA

PATIENT INFORMATION (Please Print) Date:_____

Name _____
Last *First* *Middle*

Date of Birth: _____ SSN_____ Male ____Female____
Address_____ Home Phone_____
City_____State_____Zip_____
Race: __Caucasion __African American __Hispanic __Oriental __Other
Email address_____None:_____ Cell Phone _____
Employer_____ Employer Phone_____

__*Minor __Single __Married __Divorced __Widowed __Separated

*If Minor: Responsible Party
Name/Address/Phone Number_____

_____

Do you have Advanced Directives Yes_____ No_____
Living Will____ Durable Power of Attorney____ Do Not Resuscitate____

Referring Physician: _____ Primary Care Physician_____

Insurance Name_____ Card Scanned ___yes ___no
Subscriber Name_____ Subscriber Date of Birth_____
Subscriber SS#_____
Secondary Insurance Name_____Card Scanned___yes___no
Subscriber Name_____Subscriber Date of Birth_____
Subscriber SS#_____

Emergency Contact_____ Relationship_____
Phone_____
OK to release Medical Information to Emergency Contact?_____
Preferred Pharmacy_____ Phone_____
Location_____ Mail Order_____

Name_____Date of Birth_____

Authorization and Release

- I authorize the release of any information including the diagnosis and the records of any treatment rendered to me or my dependent to third party payers and/or other health practitioners.
- I authorize you to transmit my medical records electronically/fax when necessary. I absolve Trinity Professional Group physicians and/or any professional providing services of any liability relating to the submission of these records.
- I authorize the release of information to my physician.
- I authorize and request my insurance company to pay directly Trinity Health System.
- I understand that my insurance carrier may pay less than the actual bill for services. Contractual adjustments with managed care contract will be accepted, but I agree to be responsible for payment of all billable services rendered on my behalf or my dependents.
- I understand that charges incurred for additional services (i.e. legal forms, letters to school/employer, insurance/disability forms, record releases) cannot be billed to my insurance and that I am financially responsible for these charges.
- I authorize that by signing this, I am consenting to treatment for myself or my dependent with a Trinity Professional Group physician and/or any professional providing services.
- I hereby give Trinity Professional Group personnel permission to leave a message on my answering machine concerning my appointment time or my dependent's appointment time.
- I authorize my physician to provide me with an injection/ immunization/vaccine. I understand the risks and benefits of the medication.

Signature of Patient/Guardian _____ Date_____

Signature of Witness_____

HIPAA CONSENT FORM

I understand that Trinity Professional Group staff is part of an organized healthcare arrangement and that these providers may share my health information for treatment, billing and healthcare operations. I have been given the opportunity to receive a copy of the organization's Notice of Privacy Practice that describes how my health information is used and shared. I understand the organized healthcare arrangement has a right to change the Notice at any time. I may obtain a current copy by contacting the hospital Registration Department or by visiting Trinity's website www.trinityhealth.com.

My signature below constitutes my acknowledgement that I have been provided with an opportunity to receive a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by the Legal Representative, relationship to patient:_____

Name_____Date of Birth_____

I hereby authorize my consent to release personal health information (which includes messages on answering machines, voicemails, and billing inquiries) to:

_____		_____
Name (s)	Phone #	Relationship
_____		_____
Name (s)	Phone #	Relationship
_____		_____
Patient's Signature		Date

So that our office may better serve you, we need to ask you a few personal questions:

Do you understand English?	Yes_____ No____
Do you have any difficulty with the following:	Yes_____ No____
Reading?	Yes_____ No____
Writing?	Yes_____ No____
Hearing?	Yes_____ No____
Vison?	Yes_____ No____
Are you an organ donor?	Yes_____ No____
Were you given Rights and Responsibilities Policy?	Yes_____No_____

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