LAKEVIEW
HEALTHCARE SYSTEM

2021

PATIENT REGISTRATION

Patient Name: _____Date of Birth: _____

Mailing Address: _____City:_____State/Zip:_____

Home Phone:_____ Cell Number:_____

Work Phone:_____ Employer Name:_____

Email address: _____ Social Security #: _____

Sex: M_____F_____ Marital Status: S_____, M_____, D_____, W_____, Other_____

Occupation: ____Employees, ____Full-Time Student, ____Part-Time Student, ___Retired___, Self-Employed___, Unemployed____

Employer:_____ Occupation:_____ Business Phone:_____

Emergency Contact: _____ **Phone:** _____

Emergency Contact Relationship to Patient:_____

Emergency Address:_____

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____

Insured Company/ Phone Number:_____

Subscriber ID (Policy Number)_____ Group ID: _____Copay:_____

Effective Date_____ Termination Date:_____

Insurance Company Address:_____

SECOND INSURANCE INFORMATION:

Name of Insured:_____

Insured Company/ Phone Number:_____

Subscriber ID (Policy Number)_____ Group ID: _____Copay:_____

Effective Date_____ Termination Date:_____

Insurance Company Address:_____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature:_____Date:_____

Patient Registration Revised 11/25/2020

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Patient Consent for Use & Disclosure of Protected Health Information & HIPAA Privacy

I hereby give my consent for Lakeview Healthcare System to use and disclose protected health information about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Lakeview Healthcare System describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lakeview Healthcare System reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lakeview Healthcare System.

With this consent, Lakeview Healthcare System may call my place of residence or other alternative location and leave a message on voice-mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Lakeview Healthcare System may mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that Lakeview Healthcare System restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Lakeview Healthcare System to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lakeview Healthcare System may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

Patient/Parent/Guardian/Patient Representative Signature: _____ Date: _____

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

Please list all the people whom we may inform about your general medical condition and diagnosis:_____

Please list all the persons that we may inform about your condition in an emergency situation only:_____

I, the undersigned certify that I or my dependent have insurance with

(name of insurance):_____

And assigned directly to Dr._____, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of the signature on ALL insurance submissions.

Responsible Party Signature:_____ Relationship to Patient:_____ Date:_____

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship

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Prescription Order Pick-up.

There may be times when you need a friend or family member to pick-up a prescription order (script) form your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) ***I wish*** to designate the following individual to pick up a prescription order on my behalf:

Name:_____Date:_____

Name:_____Date:_____

(Patient/Representative Initials) ***I do not want*** to designate anyone to pick-up my prescription order (script)

Patient/Parent/Guardian/Patient Representative Signature: _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed): _____

Advance Directive/ Living Will/ Power of Attorney/ 5 Wishes/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: We would like a copy for our records.

_____ I have executed an Advanced Directive

_____I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

_____Living Will

_____Durable Medical Power of Attorney

_____5 Wishes

_____Do Not Resuscitate (DNR)

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Consent to Release Confidential Information

Patient Name: _____Date of Birth: _____

I hereby authorize request that a copy of my medical records be released as follows: (circle one)

RECORDS TO BE RELEASED TO/FROM:

Lakeview Healthcare System

4685 N. HWY19A, Mount Dora, Fl. 32757

Phone: (352) 589-5900 Fax: (352) 589-5904

RECORDS TO BE RELEASED FROM/TO:

_____

_____

_____

_____This release is to cover **ALL records** contained in my file.

_____This release is to cover **ALL hospital records** needed for continuum of care

_____This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Any psychiatric records/ treatment
_____ Any drug related records/ treatment
_____ Any alcohol related records/ treatment

I understand that the purpose of the record release is for continuity of my medical care. The information contained in my medical records (s) may include diagnosis, evaluation and/ or treatment of any mental or emotional condition (s). This may also include alcohol and/ or drug related addictions. Information regarding HIV infection with any probable causative agent of AIDS are also considered a part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying and providing Lakeview Healthcare System in writing. The written revocation will be effective on the date of notification except to any actions already taken. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. By authorizing the use or disclosure if information, there will be no conditions placed on my health care of payment of my health care. I have the right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/ or supervising inspections of medical records.

_____ _____

Patient/Parent/Guardian/Patient Representative Signature Date

_____ _____

Witness Date

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Patient Responsibility Form

The patient is responsible for providing Lakeview Healthcare System with the most correct, active and up to date information about their insurance prior to each visit.

Lakeview Healthcare System will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.

Patients are responsible for the payment of co-pays at the time of service.

Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.

Lakeview Healthcare System is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance

In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.

Patients have the right to check with their insurance about coverage before receiving any service provided at Lakeview Healthcare System.

The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether our physicians participate.

The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.

If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.

The patient agrees that in return for the services provided to them by Lakeview Healthcare System, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If copayments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Lakeview Healthcare System.

Worker's Compensation and Automobile Claims. Lakeview Healthcare System does not accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Lakeview Healthcare System policies regarding patient responsibilities.

_____ _____

Patient/Parent/Guardian/Patient Representative Signature Date