PATIENT REGISTRATION

(Updated 1/03/2025)

PATIENT INFORMATION: (IF SEVERAL CHILDREN PLEASE LIST NAMES AND DATES OF BIRTH)

NAME: _____

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SEX: M F HOME #: _____ Cell #: _____

E-MAIL ADDRESS: _____
(By providing your email address and cell phone number you are consenting to Liberty Medical Center staff to use it to send appointment reminders, balances, etc.)

MARITAL STATUS (PLEASE CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER: _____

EMPLOYER PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME #: _____ WORK #: _____

INSURANCE CARRIER: _____

INSURANCE POLICY HOLDER:
NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SEX: M F HOME #: _____ WORK #: _____

SSN: _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY EMPLOYER: _____

EMPLOYER PHONE #: _____

I authorize payment of medical benefits to be made directly to Liberty Medical Center.

Patient/Guardian Signature: _____

(TURN OVER)

Please initial each paragraph:

_____I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Obtain payment from third-party payers*; *Conduct normal healthcare operation, such as quality assessments and physician certifications*; *Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

_____ I have been informed by you of your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

_____ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

_____ We have adopted a policy that requires authorization from the patient to leave a detailed message for that patient. This is to protect the privacy of the patient and to protect the physician and staff of this practice from violating the patient's confidentiality. If there is not a signed consent on file, Dr. Malisos or the staff will only leave their name and telephone number on an answering machine, voicemail, or with a person answering the phone asking the patient to return the call.

By completing the consent below, you are allowing this medical office and its staff to leave a message on an answering machine, email, voicemail, or with a specified individual. You can specify what information is left and with whom. By signing, you are also consenting to the mailing, emailing or faxing of any results requested by you or another physician involved in your care.

I give my consent to Rodney Malisos, MD and the entire staff of Liberty Medical Center to leave a message regarding scheduling, treatment, surgery, lab, radiology results, or other information as necessary

_____ **I DO NOT** consent to messages being left at home, work, or with any other person.

_____ **I DO** consent to leaving messages on answering machine, email or voicemail at home or cell phone or work.
(please cross off any contact method you are not comfortable with being contacted at)

I give consent to share any and all medical history:

_____ With _____ Relationship _____

_____ With _____ Relationship _____

_____ With _____ Relationship _____

_____ _____
Patient's Name (Print) DOB

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Liberty Medical Center believes in communicating our office and financial policies to our patients and want you to have a full understanding of these policies. **Please initial each paragraph:**

_____ **PAYMENT:**
We appreciate prompt payment in full for any outstanding balance. This includes any deductible, co-insurance, co-payment amount, and charges not covered by your insurance company. If have choose to move forward with a self-pay service, do not carry insurance, or if your coverage is not accepted at our office; payment in full is expected at the time of service.

_____ **INSURANCE:**
We are participating providers with most commercial insurance plans, however it is your responsibility to ensure that we are in-network with your specific plan. Please remember that insurance is a contract between **the patient** and **the insurance company**, therefore it is imperative that you are aware of your plans benefits and restrictions. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. In the event your insurance carrier/company denies the services provided, you will be responsible for the full amount. In order to bill your insurance and meet filing guidelines we are required to ask for a copy of your insurance card and a photo ID.

_____ **BILLING AND COLLECTION FEES:**
Liberty Medical Center will submit a claim for payment to your insurance company. It is important that we are provided correct or updated insurance information at the time of your appointment so that services can be billed within the required time frame given by the insurance. If incorrect insurance information is provided, you may be responsible for the entire bill. After 90 days of no payment activity on your account, it is deemed eligible for submission to a collection agency. Once your account is submitted to the collection agency, you will be assessed an additional $100.00 fee to cover the fees imposed to Liberty Medical Center by the collection agency. Accounts sent to collections are inactivated and ineligible for re-activation.

_____ **NO SHOW/LATE CANCELLATION**:
We understand that situations arise in which you must cancel your appointment. If you need to cancel your appointment, you must provide at least a 24-hour notice prior to your appointment time. Patients who do not show up or fail to provide a 24-hour notice are considered a NO SHOW and will be assessed a **$50.00 fee**. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice. If you are more than 15min late for your appointment you will be assessed a **$50** fee and will need to reschedule the appointment. If we are able to work you in again on the same day, the **$50** late fee will still apply.

_____ **WELLNESS/SICK VISITS**:
Our goal at Liberty Medical Center is to provide you with the best medical care possible, therefore **we do require all of our patients to remain up to date with yearly adult/child wellness exams**. Annual physical exams give us a chance to monitor and address your overall physical and emotional health. Office/sick visits differ from the preventative and wellness care that are provided in an annual physical exam visit. These types of services need to be addressed separately from your annual wellness appointment. After three years of inactivity, a patient will be inactivated and we will require a new patient deposit to re-establish if you wish to continue care.

I have read and understand the practice's office and financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guardian _____ Date_____

(TURN OVER)

(MUST BE COMPLETED IN ORDER TO BE SEEN)

CREDIT CARD ON FILE AGREEMENT

Liberty Medical Center has implemented a new credit card policy. We will be keeping a credit card on file for each patient account which will be used for payment of any self-pay balances due after insurance. This balance could include your co-pay, co-insurance, and/or deductible. This card will also be used for any account eligible for collections and any no show or late cancellation fees. At check in, your credit card information will be obtained and kept securely in your file.

If you have any questions about our policies, please ask.

By signing below, I authorize Liberty Medical Center to keep my signature and my credit card information securely on-file in my account. I authorize Liberty Medical Center to charge my credit card for any self-pay balances after insurance, no show or late cancellation fees when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Liberty Medical Center a new, valid credit card which I will allow them to charge over the telephone. Even though Liberty Medical Center is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Visa □ MasterCard □ Discover □

Patient's Name (Print): _____ DOB: ___/___/_____
Name on Card (Print): _____
Credit Card Number: _____ CVV _____ Exp. Date: ___/___

Is this an HSA card? □ Yes □ No

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____

By verbally agreeing to these terms and/or by signing this form, I agree to allow Liberty Medical Center to charge my credit card for all expenses I owe.

Credit Card Holder's Signature: _____ Date: _____

****ANY DISPUTES MADE WITH YOUR CREDIT CARD COMPANY WILL BE ELIGIBLE FOR DISMISSAL FROM LIBERTY MEDICAL CENTER. PLEASE CALL OUR OFFICE IF YOU DO NOT AGREE WITH A CREDIT CARD CHARGE.**