



## **Patient Registration & Consent to Treat**

2412 Ring Road ~ Elizabethtown, KY 42701  
Phone (270) 765-5926 Fax (270) 763-0051

## **Patient Registration & Consent to Treat**

### **INSTRUCTIONS FOR COMPLETING THIS FORM**

**Complete all required sections.  
Sign and date form.**

**You may:  
Drop by office**

**Fax  
(270-763-0051)**

**Mail  
2412 Ring Road, Suite 200  
Elizabethtown, KY 42701**



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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

(If patient is a minor, complete back page also)

Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Gender:  M  F

Marital Status:  Single  Married  
 Divorced  Widowed

Emergency Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Authorization to Release Information to Significant Other

\_\_\_\_\_ I hereby authorize telephonic/electronic release of medical information to the following person:  
initials

Relationship:  Spouse  Parent  Child  Other

### PRIMARY INSURANCE

Primary Ins : \_\_\_\_\_

ID#: \_\_\_\_\_ Grp# \_\_\_\_\_

Holder of Ins: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship:  Spouse  Parent  Child  Other

### SECONDARY INSURANCE

Secondary Ins : \_\_\_\_\_

ID#: \_\_\_\_\_ Grp# \_\_\_\_\_

Holder of Ins: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship:  Spouse  Parent  Child  Other

I hereby give consent for treatment of myself, or the named minor child, by the physicians, physician assistants, nurse practitioners and/or staff of Heartland Primary Care.

I authorize the release of any medical information necessary to process all insurance claims including but not limited to workers compensation claims. Further, I release payment of medical benefits to Ingram and Ball, PLLC (dba Heartland Primary Care).

I understand that I am responsible for payment of co-payments and co-insurance at the time of service.

I understand that I am fully responsible for any unpaid account balances, including but not limited to co-payments, co-insurance and deductibles not paid by the insurance carrier. Accounts not paid in full within 30 days may be subject to a finance charge of up to 18% annually. In addition, should my account become delinquent and referred to a collection agency, I understand that I will be responsible for the balance owed on the account plus all costs incurred in collecting the balance.

\_\_\_\_\_  
Patient Signature or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



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## Additional Information for Minor Children

Parental Marital Status:  Married  Divorced  Separated  Other  
If divorced, who has primary custody?  Father  Mother  Both  Other: \_\_\_\_\_

Who is financially responsible for this child's medical care?  Father  Mother  Both  Other: \_\_\_\_\_

FATHER's INFORMATION	MOTHER's INFORMATION
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Not Applicable
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Social Security #: _____	Social Security #: _____
<input type="checkbox"/> Information same as front	<input type="checkbox"/> Information same as front
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
<input type="checkbox"/> Information same as front	<input type="checkbox"/> Information same as front
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____
<input type="checkbox"/> Information same as front	<input type="checkbox"/> Information same as front
Employer: _____	Employer: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____

I hereby authorize Heartland Primary Care to release any and all medical information pertaining to this minor child to:

Father  Mother  Other: \_\_\_\_\_

Parent/Legal Representative of Minor Child

Relationship to Patient

Date