



### Patient Registration & Consent to Treat

2412 Ring Road ~ Elizabethtown, KY 42701  
Phone: (270) 765-5926 Fax: (270) 763-0051  
www.heartlandprimarycare.com

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(If the patient is a minor, complete back page also)

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Gender:  M  F  
Marital Status:  Single  Married  
 Divorced  Widowed

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relation to you: \_\_\_\_\_

**Authorization to Release Information to Significant Other**  
\_\_\_\_\_ I hereby authorize telephonic/electronic release of  
Initials medical information to the following person:  
Name: \_\_\_\_\_  
Relationship:  Spouse  Parent  Child  Other

#### PRIMARY INSURANCE

Insurance Name: \_\_\_\_\_  
ID # \_\_\_\_\_ Grp # \_\_\_\_\_  
Holder of Ins: \_\_\_\_\_  
SS # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship:  Spouse  Parent  Child  Other

#### SECONDARY INSURANCE

Insurance Name: \_\_\_\_\_  
ID # \_\_\_\_\_ Grp # \_\_\_\_\_  
Holder of Ins: \_\_\_\_\_  
SS # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship:  Spouse  Parent  Child  Other

Do you have a medical power of attorney, living will, or advance directive?  Yes  No  I don't know  
If you have one of the above, please bring a copy for your file here. If you have questions about a medical power of attorney, living will, or advance directive, please ask your provider during your appointment.

I hereby give consent for treatment for 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 any applicable co-payments, co-insurance, and deductibles 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 my 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: _____ SS # _____	Date of Birth: _____ SS # _____
<input type="checkbox"/> Information Same as Front	<input type="checkbox"/> Information Same as Front
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
<input type="checkbox"/> Information Same as Front	<input type="checkbox"/> Information Same as Front
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Email Address: _____	Email Address: _____
<input type="checkbox"/> Information Same as Front	<input type="checkbox"/> Information Same as Front
Employer: _____	Employer: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____

I hereby authorize the following named person to accompany my minor child to Heartland Primary Care. In the absence of myself or the minor child's other legal guardian, I authorize the following named person to make decisions regarding the child's health and medical treatment by the physicians, physician assistants, nurse practitioners, and/or staff of Heartland Primary Care. All payment is still expected at the time of service. This authorization expires one year from today's date and may be rescinded at any time by notifying the staff of Heartland Primary Care.

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

The minor child is only to be treated by Heartland Primary Care if he/she is with myself or another legal guardian

The minor child is between the ages of 16-18 and can drive him/herself to Heartland Primary Care. In the event of my absence, I hereby authorize the minor child to make their own decisions regarding their health and medical treatment by the physicians, physician assistants, nurse practitioners, and/or staff of Heartland Primary Care. All payment is still expected at the time of service. This authorization expires one year from today's date and may be rescinded at any time by notifying the staff of Heartland Primary Care.

Yes  No  Not applicable

If the above information is left blank/checked no, a legal guardian must be present for the child to be seen at Heartland Primary Care.

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

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

Signature of Parent/Legal Guardian of Minor Child

Relationship to Patient

Date