
***Celeste B. Hart, MD***
***Luz M. Prieto-Sanchez, MD***
***Robin P. Byrd, ARNP***
***1705 S. Adams Street - Tallahassee, Florida 32301***
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# NEW PATIENT REGISTRATION FORM

**Personal Information (Please print)**

Date: _____

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ (mm/dd/yyyy) Gender: ___ Female ___ Male

Address: _____

City/State/Zip: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Spouse's Name: _____ Contact Number: _____

**Insurance Information** (insurance card required upon arrival of your appointment)

Primary Insurance: _____

Insurance Group/Policy Number: _____

**Emergency Contact Information**

Name: _____ Relationship to Patient: _____

Home Phone #: (___)_____ Other Phone #: (___)_____

Patient's Name: _____Date of Birth: _____

**Financial Agreement**

This is an agreement between North Florida Regional Thyroid Center and Patient Name: _____ Legal Guardian_____.

By signing this agreement, patient is agreeing to pay for services/ procedures rendered by Celeste B. Hart, MD, Luz Prieto-Sanchez, MD or Robin Byrd, ARNP.

Patient understands he/she is responsible for payment of any outstanding charges not covered by primary insurance company. Co-Payments are paid at the time of visit.

Patient authorizes the release of any medical information necessary to process insurance claims; also authorize benefits to be paid directly to North Regional Thyroid Center on patient's behalf.

**If patient has no insurance, payment in full is due before services are rendered.**

Patient Name (print): _____

*Guardian Name (if patient is a minor): _____

Signature: _____ Date: _____

***Minors cannot sign agreement. Must be signed by parent or guardian.**

## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information by **North Florida Regional Thyroid Center** for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **North Florida Regional Thyroid** C**enter**. I understand that consent as evidenced by my signature on this document.

I understand I have the right to request as to how my protected health information is used or disclosed to carry out treatment, payment of healthcare operations of the practice. **North Florida Regional Thyroid Center** is not required to agree to the restrictions that I may request. However, if **North Florida Regional Thyroid Center** agrees to a restriction that I request, the restriction is binding on **North Florida Regional Thyroid Center**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **North Florida Regional Thyroid** Center has taken action in dependence on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **North Florida Regional Thyroid Center's** Notice of Privacy Policy prior to signing this document. **The North Florida Regional Thyroid Center** Notice of Privacy Policy has been provided me. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the North Florida Regional Thyroid Center. This Notice of Privacy also describes my rights and the North Florida Regional Thyroid Center's duties with respect to my protected health information.

**North Florida Regional Thyroid Center** reserves the right to change the privacy polices that are described in the Notice of Privacy Policy. I may obtain a copy of such revision at any time.

_____ _____

Printed Name of Patient or Personal Representative Signature of Patient or Representative

Personal Representative Relationship to Patient: _____ Date: _____

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I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

**Patient signature:** _____ Date: _____

**Signature of Responsible Party** (if different than patient): _____

Relationship: _____

I hereby authorize Dr. Celeste Hart to apply for benefits on my behalf for covered services by her or by her order. I request that payment from my insurance company be made directly to Dr. Celeste Hart (or to the party who accepts assignment).

I permit a copy of this authorization to be used in place of the original. Either I or my insurance company at any time may revoke this authorization, in writing.

**Patient Signature:** _____ Date: _____

**Signature of Responsible Party** (if different than patient): _____

Responsible Party Relationship to Patient: _____

## Confidentially Agreement (optional)

I, _____authorize Dr. Hart and/or any authorized medical staff member to discuss my medical condition and/or billing information with the following person(s).

I do acknowledge that a written authorization is required in order to release any medical records to this/these individuals.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Guardian Signature: _____ Date: _____

***Minors cannot sign agreement. Must be signed by parent or guardian.**