MedStar Physician Partners

MPP Family Practice
18109 Prince Philip Drive
Suite B-200
Olney, Maryland 20832
Phone: 301-570-7770 Fax: 855-256-6851

PATIENT REGISTRATION AND AUTHORIZATION FORM

Patient Information:

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

Street: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

Date of Birth: _____ **Social Security #:** _____

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Hispanic ☐ Hawaiian/Pac Island ☐ Multiracial

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Student: ☐ Yes ☐ No (Skip Employment information if non-applicable)

If Retired or Disabled (no longer working), please provide retirement/disability date: _____

Patient Employment Information:

Occupation: _____ **Employer:** _____

Street: _____ **Suite #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Alternative Work Contact Number: _____

Emergency Contact Information:

Name: _____ **Relationship to Patient:** _____

Street: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Primary Insurance Information:

Plan Name: _____

Plan ID #: _____

Plan Group #: _____

Subscriber's name: _____

Subscribers Date of Birth: _____

Subscribers relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance Information:

Plan Name: _____

Plan ID #: _____

Plan Group #: _____

Subscriber's name: _____

Subscribers Date of Birth: _____

Subscribers relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Please Note: A copy of your health plan identification card(s) and a photo ID is required. Please give the cards to the receptionist for photocopying and confirmation of benefits. Your cards must be available at each visit. Your co-payment must be paid at the time of service.

Insurance Authorization and Assignment:

I hereby authorize my attending physician to furnish to the insurance carriers listed above my illness and treatments.

SIGNATURE: _____ DATE: _____

I hereby assign to my attending physician all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by insurance at the time of service. I also understand that I am responsible for collection and legal costs should it be necessary for this account to be turned over to collection agency.

SIGNATURE: _____ DATE: _____

Privacy Practices and Advance Directive:

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

Would you like information regarding Advance Directive? ☐ Yes ☐ No

I acknowledge that I have received the MedStar Health Notice of Privacy Practices Booklet (HIPAA PRIVACY ACT).

SIGNATURE: _____ DATE: _____