Gulf Coast Medical Center

New Patient Registration

Please have all INSURANCE CARDS and DRIVER'S LICENSE or PHOTO ID ready to copy.
(PLEASE PRINT)

Today's Date: _____ Account #:_____

LAST NAME	FIRST	MI	SEX ❑ MALE ❑ FEMALE ❑ TRANSGENDER	❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑ SIGNIFICANT OTHER

SOCIAL SECURITY NO. - -	DATE OF BIRTH / /	RACE	ETHNICITY	☐ EMPLOYED ☐ RETIRED ☐ STUDENT ☐ UNEMPLOYED

LOCAL ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELLULAR PHONE

EMAIL ADDRESS	LANGUAGE PREFERENCE ❑ ENGLISH ❑ SPANISH ❑ OTHER_____ ❑ HEARING IMPAIRED ❑ VISION IMPAIRED

EMAIL ADDRESS NOTIFICATION
❑ DO NOT WISH TO BE CONTACTED ❑ YES, I WOULD LIKE TO BE CONTACTED BY EMAIL AND USE ONLINE FEATURES PROVIDED BY GCMC

PERMANENT ADDRESS	CITY	STATE	ZIP CODE

PREFERRED PHARMACY	PREFERRED PHARMACY PHONE

IN CASE OF EMERGENCY, CONTACT:

LAST NAME	FIRST

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE	RELATIONSHIP

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ❑ YES ❑ NO IF NO, PLEASE COMPLETE THIS SECTION

RELATIONSHIP	SEX ❑ M ❑ F	DAYTIME PHONE

FIRST NAME	MIDDLE	LAST NAME

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER

EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE INFORMATION ***PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST***

INSURANCE COMPANY	INSURED'S DOB

INSURANCE/CARD HOLDER'S NAME	RELATIONSHIP

ID #	GROUP #	PHONE

SECONDARY INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME	INSURED'S DOB

INSURANCE/CARDHOLDER'S NAME	RELATIONSHIP

ID#	GROUP #	PHONE

IS THE REASON FOR TODAY'S VISIT THE RESULT OF AN ACCIDENT? ❑ YES ❑ NO IF YES, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

Please Read and Sign Back Date Scanned: _____ Initials: _____ Account Number: _____

1. **CONSENT FOR TREATMENT.** I understand that medical treatment of an immediate nature may be necessary for the patient and that such medical care, treatment, and procedures will be performed by licensed physicians and/or employees of **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** during posted operating hours. I understand that medical treatment only is being provided and I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, that may be obtained. I understand and recognize that **GULF COAST MEDICAL CENTER** is a teaching facility.
   Do you have an Advance Directive? ❑ Yes ❑ No
   Would you like information pertaining to Advance Directives? ❑ Yes ❑ No
2. **PRESCRIPTION DRUG MONITORING PROGRAM (PDMD).** Patient gives Gulf Coast Medical Center and its providers and/or designees of prescribing provider permission to consult the Prescription Drug Monitoring Program prior to dispensing prescriptions for all controlled substances to review dispensing history, as required by the State of Florida (Florida House Bill 21 (2018).
3. **FINANCIAL RESPONSIBILITY.** For and in consideration of the care and treatment provided to the patient, I promise to pay **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** all charges for services rendered to or on behalf of the patient. Any services that are not covered by insurance are the patients' responsibility and will be due and payable at the time services are rendered unless other arrangements are made in advance. Patient is also responsible for the costs of collection of any amounts due **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER**, to include reasonable attorney's fees and court costs.
4. **RELEASE OF MEDICAL INFORMATION.** I hereby authorize **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** to release any medical information, in connection with these services, requested with regard to processing my claim or to my personal physician, insurance carrier, and/or attorney of record with appropriate release.
5. **DIAGNOSTIC TESTING.** Please be aware of YOUR insurance policy exclusions with regard to diagnostic testing. Although **GULF COAST MEDICAL CENTER** strives to provide our patients with any type of diagnostic testing he/she may need, certain insurance companies have specific facilities you must go to for certain tests, i.e., laboratory, X-ray procedures. It is your responsibility to verify that procedures performed at **GULF COAST MEDICAL CENTER** are covered by your insurance policy. The patient is ultimately held responsible for any balance due to the reason stated above.
6. **MEDICARE/MEDIGAP, BLUE CROSS/BLUE SHIELD OR OTHER HEALTH INSURANCES.** I hereby authorize **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I hereby request reimbursements from any applicable insurance to be made directly to **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER.** I certify that the information I have provided with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, as well as any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medigap benefits be made on my behalf to **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER.** I release any holder of Medicare information about me to my insurance carriers, necessary to determine benefits payable for related services.
7. **ATTORNEY OF RECORD:** I authorize my attorney to release to **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** any information detailing my case, case status, or case settlement in connection with date of accident _____ and medical services rendered.
8. **AUTHORIZATION TO APPEAL DETERMINATION.** I authorize the Billing Department of **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** to act on my behalf, as a Designated Representative, to appeal my insurance carrier's determination, if necessary. I understand that communications may contain confidential medical and financial information, including, but not limited to, treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand the confidential information will only be released as specified in the authorization, or as permitted by law. This authorization is valid for a period of one year.
9. **CONSENT TO PHOTOGRAPH.** I understand that services conducted by **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** may be photographed. The photographs are used to assist in trainings and also as an important tool of the services provided. I understand my information and identity will remain confidential and protected.
10. **CONSENT TO RECEIVE AUTOMATED CALLS.** I consent to receive calls from **S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER** for my protected healthcare and other services at the phone number(s) listed on the front of this form, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.
11. **The policy of this facility is to call 911 for all emergencies within the medical center.**

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED BY S.M.S., D.O., P.A., **d/b/a** GULF COAST MEDICAL CENTER AND ANY OF ITS DULY AUTHORIZED AGENTS TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS. I ALSO UNDERSTAND THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Account Number

❑ BROCHURE GIVEN ❑ NOTICE OF PRIVACY PRACTICES POLICY SIGNED Date Scanned: _____ Initials: _____