Atlas Medical
7227 E. Baseline Rd. Suite 126 Mesa, AZ 85209
Office- 480-868-9650 ● Fax- 480-834-3606
Office@AtlasMedicalCare.com

PATIENT REGISTRATION

First Name: ___________________________ Last Name: ____________________________ (MI): _______

DOB: _____ / _____ / _____ Sex: M / F Patient Personal Cell: ________________________________

Preferred Language: _______________Race: __________________Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Community/Facility Name: ___________________________ Facility Move-in Date: _____ / _____ / _____

Social Security Number: ________________________ Medicare Number: ___________________________

Prior Primary Care Provider

Contact: ____ Phone #: _________________

Current Specialists

Contact: ___________________________________ Phone #: _________________ Specialty: __________

Contact: ___________________________________ Phone #: _________________ Specialty: __________

☐ I <u>AM ON</u> Hospice (Hospice Company: ____)

☐ I <u>AM ON</u> Home Health (PT/OT/Skilled Nursing) (Home Health Company: _________________________)

☐ I <u>DO</u> have a Medical Power of Attorney (MPOA) ☐ I <u>DO NOT</u> have a Medical Power of Attorney

MPOA or Primary Contact: ________________________________ Relation to Patient: _______________

Primary Phone #: ____________________________ Email Address: ________________________________

Mailing Address: ____________________________ City: __________________ State: _____ Zip: _______

☐ I <u>DO</u> have a Guarantor or Financial POA (FPOA) ☐ I <u>DO NOT</u> have a Guarantor or Financial POA

FPOA or Guarantor: ______________________________________ Relation to Patient: _______________

Primary Phone #: ____________________________ Email Address: ________________________________

Mailing Address: ____________________________ City: __________________ State: _____ Zip: _______

-Please complete all sections that apply-

Without accurate insurance information we will be unable to bill your insurance and we will have to bill you directly.

PRIMARY INSURANCE (Medicare, Medicare/Medicaid Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name: ____

Member ID# ____

SECONDARY INSURANCE (Medicare Supplement Plan, Medicaid, or "Medigap" Plan) (Part F, G, K, L, M, N, Etc)

Insurance Provider and Plan Name: ____

Member ID# ____

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Name of Patient: ____

Date of Birth: ____ /____ /____ Community/Facility Name: _____________________________

MEDICAL CONSENT

I hereby request medical care and treatment by Century Care Inc DBA Atlas Medical (Atlas Medical). I request evaluation and/or treatment by:

☐ Outpatient Physical, Occupational and Speech Therapies ☐ Podiatry ☐ ________________

FINANCIAL RESPONSIBILITY

I authorize Atlas Medical to bill my Insurance and for my insurance company to make direct payments to Atlas Medical. I accept full financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. <u>I am aware that the only bills I will receive from Atlas Medical will be for Deductibles, Copays, and Coinsurance; Atlas Medical will not bill me personally for any services denied by my insurance</u>. I understand that it is my responsibility to continuously provide up-to-date Insurance information or select a cash payment plan with Atlas Medical.

NOTICE OF PRIVACY PRACTICES

Medical information is considered private and confidential; however, I am aware, that my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing. Atlas Medical participates in Government Health Information Exchange (HIE) programs to which you can opt out at any time. Furthermore, I understand that Atlas Medical may disclose my health information when required to do so by law.

RELEASE OF MEDICAL RECORDS

I authorize the release of my complete health record to Atlas Medical; this authorization for release of information covers all past and present medical records, unless otherwise specified, which may include records relating to communicable diseases, and treatment of alcohol or drug abuse.

TRANSFER OF CARE

I understand that Atlas Medical may not remain as my Provider in the event that I move from my current care facility. Atlas Medical also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if I desire a change in provider for any reason that prompt <u>written</u> notification be sent to Atlas Medical. Furthermore, I understand that Atlas Medical may change my assigned Provider/Therapist to any of Atlas Medical's Associate Providers/Therapists at any time without prior notice.

My Signature below certifies that I have read, understand and consent to all the terms and conditions listed above.

____

Signature of patient or Legal POA Date