



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

PODIATRY PATIENT REGISTRATION

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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: _____

Current Primary Care Provider

Contact: _____ Phone #: _____

Current Specialists

Contact: _____ Phone #: _____ Specialty: _____

Contact: _____ Phone #: _____ Specialty: _____

☐ I **AM ON** Hospice (Hospice Company: _____)

☐ I **AM ON** Home Health (PT/OT/Skilled Nursing) (Home Health Company: _____)

☐ I **DO** have a Medical Power of Attorney (MPOA) ☐ I **DO NOT** have a Medical Power of Attorney

MPOA or Primary Contact: _____ Relation to Patient: _____

Primary Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

☐ I **DO** have a Guarantor or Financial POA (FPOA) ☐ I **DO NOT** 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: _____ Page 2 of 2

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:

☐ 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. 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. 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 written 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