Patient Registration Information

Mayo Clinic/Medical Record Number

Patient Name

Birth Date

(Mayo Clinic/Medical Record Number, Patient Name and Birth Date Above)

Have you ever been a patient or made an appointment at Mayo Clinic in ☐ Arizona ☐ Florida ☐ Minnesota ☐ MCHS ☐ No

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ________		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ________	
Name *(Last, First, Middle Initial)*			Mayo Clinic No.
Permanent Address		City	State / Zip
Home Phone Number		Cell Phone Number	
Where are you staying locally?		Phone Number	
Dates you will be at this address	Social Security Number	Birth Date *(Month DD, YYYY)*	Sex ☐ Male ☐ Female
Occupation		☐ Full Time ☐ Part Time ☐ Student ☐ Retired ________ *dd/mm/yy*	
Employer		Employer Phone Number	
Address		City	State / Zip
Email Address	Preferred Communication	Patient Needs	
Race / Ethnicity	Religion	Preferred Language	Interpreter Needed ☐ Yes ☐ No

Spouse, Emergency Contact, Next of Kin or Guarantor (for minors), if applicable

Name *(Last, First, Middle Initial)*	Relationship	Language		Interpreter Needed ☐ Yes ☐ No
Address ☐ check if same as above	City	State	Zip	Birth Date *(Month DD, YYYY)*

Additional Contact Information

Name ☐ check if interpreter needed	Phone Number	Relationship

Please attach a copy of the front and back of all active insurance card(s).

Primary Insurance Information **Insurance Effective Date** ________

Insurance Company Name		Group No.	Precertification Phone Number	
Claim Address		City	State	Zip
Employer of Subscriber	Subscriber's ID No.	Subscriber's Relationship to Patient	Subscriber's Birth Date *(Month DD, YYYY)*	

Additional Insurance Information **Insurance Effective Date** ________

Insurance Company Name		Group No.	Precertification Phone Number	
Claim Address		City	State	Zip
Employer of Subscriber	Subscriber's ID No.	Subscriber's Relationship to Patient	Subscriber's Birth Date	

Is this visit Worker's Compensation or Motor Vehicle related (please check one)? ☐ Yes ☐ No

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Mayo Clinic Authorizations and Service Terms

Mayo Clinic/Medical Record Number

Patient Name

Birth Date

(Mayo Clinic/Medical Record Number, Patient Name and Birth Date Above)

Authorizations

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Mayo Clinic* medical staff consider to be necessary. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization to Release Medical Information:** I authorize Mayo Clinic to release all medical information as necessary to:

- All Payers*** for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Mayo Clinic entities for the purpose of providing information regarding the services and goods of Mayo Clinic and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Mayo may not condition treatment, payment, enrollment, or eligibility for benefits on your agreeing to this provision.
- I authorize Mayo Clinic and my insurer(s) to share my past, current and future health, treatment and account records about services I've received from Mayo Clinic and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

Authorization to Assign Benefits and Release Information to Mayo Clinic: I authorize my Payer(s) to pay directly to Mayo Clinic any benefits due under the terms of my health care plan(s) for services provided by Mayo Clinic. I understand Mayo Clinic reserves the right to refuse or accept assignment of medical benefits. If my health care plan(s) will not allow direct payment to Mayo Clinic or if Mayo Clinic chooses not to accept assignment of medical benefits, I agree to pay Mayo Clinic all health care payments I receive for services. I authorize Mayo Clinic to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to Mayo Clinic.

Service Terms

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), an out-of-state workers' compensation policy, or any other payer. Mayo Clinic may participate in certain government programs and does comply with applicable billing terms and restrictions. I agree that Mayo Clinic may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by contacting Patient Account Services at 800-660-4582, or online at mayoclinic.org or mayoclinichealthsystem.org.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to health care services rendered by Mayo Clinic is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Use of Cell Phone: I agree Mayo Clinic, its affiliates and agents may use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provide to Mayo Clinic for appointment and payment purposes.

Notice of Privacy Practices: I acknowledge I have been presented with the Mayo Clinic Notice of Privacy Practices. To view an electronic version of this document, see: http://www.mayoclinic.org/about-mayo-clinic/notice-of-privacy-practices. I understand I can request a paper copy during my visit or by calling 507-266-6286.

ATTENTION: Changes will not be accepted on this form. Requests for alterations must be made by calling Mayo Clinic Registration at 507-284-3350. This is a legal document. By signing, you agree that you understand and accept the terms on this form. *I understand I have the right to revoke the authorizations on this form at any time by notifying Mayo Clinic in writing, except to the extent that Mayo Clinic has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.*

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form.
  Please indicate your legal authority and include documentation of your relationship:
  ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent *(Health Care Power of Attorney)*** ☐ **Other Legal Representative**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ **Parent** ☐ **Legal Guardian**

Signature	Signature Date	Signature Time

Printed Name of Person Signing *(If Not Patient)*

* For purposes of this form, Mayo Clinic refers to Mayo Clinic in Arizona, Florida, Rochester, Mayo Clinic Health System and all affiliated clinics, hospitals, and entities; including employees and agents.

** Medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment if such information exists.

*** For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

Mayo Clinic Use Only

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