Please complete, print and submit.

Reset Form

MAYO CLINIC

Patient Information and Mayo Clinic Authorizations and Service Terms

Mayo Clinic Number *(if known)*	Patient Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Instructions:

1. Please complete all information on this form.
2. If you have access to a copy machine, please enclose copies of both sides of your insurance card(s) on a full sheet of paper.
3. If you are 18 years of age or older, sign and date the last page of this form. If you are 17 years of age or younger, a parent or legal guardian must sign and date the last page.
4. Return all pages of this form to Registration or you may fax to Registration at (507) 266-5305.
5. If you have questions or need assistance, please call Registration at (507) 284-2421 between 8 a.m. and 5 p.m. (Central Standard Time), Monday through Friday.

Patient Demographic Information

Full Legal Name *(Last, First, Middle)*					
Suffix	Salutation *(Mrs., Mr., Ms., Miss)*	Birth Date *(Month DD, YYYY)*	Age	Sex	Marital Status
Home Phone	Cell Phone	Social Security Number		Religious Affiliation	

Address *(Street, City, State and ZIP)*	What language do you feel most comfortable speaking with your doctor or nurse?
	If not English, do you require an interpreter? ☐ Yes ☐ No
Country / Fax	If you are receiving services at Mayo Clinic in Arizona or Mayo Clinic in Florida: ☐ Oxygen Therapy ☐ Stretcher Transportation ☐ Portable Lift Required
Patient Conditions ☐ Hearing Impaired ☐ Visually Impaired/Legally Blind ☐ Wheelchair ☐ Diabetic/Insulin-Taking Diabetic	
E-mail	

Secondary Address *(i.e., summer or winter home)*

Address *(Street, City, State and ZIP)*	Effective From and To Dates *(Month DD, YYYY to Month DD, YYYY)*
	Country / Home Phone

To help verify previous registration data and/or determine if you have a medical record on file, please provide the following:

Full Name of Patient's Spouse *(whether living or deceased)*	Patient's Maiden Name
Other Names of Patient *(such as hyphenated names or full name from a previous marriage)*	

If you have EVER received care as a child or an adult from a Mayo Clinic physician or at a Mayo Foundation facility, you will have a medical record on file. Indicate if you have ever received care:

☐ From a Mayo Clinic physician or provider
☐ At a Mayo Clinic Health System site
☐ At Mayo Clinic or Mayo Clinic Hospital in Florida
☐ At Mayo Clinic or Mayo Clinic Hospital in Arizona
☐ At Mayo Clinic in Rochester, Minnesota, Rochester Methodist Hospital, or Saint Marys Hospital

Mayo Clinic Personnel Use Only	Outreach Section	Appointment Date	Section to Register Patient	Phone Extension

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Race and Ethnicity

Identifying your race and ethnicity assures that everyone gets appropriate access to the health care they need. The information you report is confidential.

Ethnicity

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
  - ☐ Mexican
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Central American
  - ☐ South American
  - ☐ Other Spanish culture or origin regardless of race (except Spain)
- ☐ Choose not to disclose

Race

- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Black or African American
  - ☐ African American
  - ☐ American-born African
  - ☐ African
  - ☐ Caribbean Black
- ☐ Native Hawaiian/Pacific Islander
  - ☐ Guamanian or Chamarro
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ Asian
  - ☐ Chinese
  - ☐ Cambodian
  - ☐ Filipino
  - ☐ Indian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Pakistani
  - ☐ Taiwanese
  - ☐ Thai
  - ☐ Vietnamese
  - ☐ Other
- ☐ Some other race
- ☐ Choose not to disclose

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Mayo Clinic Number *(if known)*	Patient Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Employment Information

Employer Name	Occupation	
Address *(Street, City, State and ZIP)*	Employment Status	
	Country	Work Phone

Contact Information *(i.e., spouse, life partner, parent, nearest relative, next of kin, friend, etc.)*

Name *(Last, Suffix, First, Middle)*	Relationship to Patient	
Address *(Street, City, State and ZIP)*	Home Phone	Work Phone
	Country	Cell Phone

Billing Addressee Information

Billing Addressee is the person you authorize to receive your monthly billing statements and to coordinate billing, payment, and insurance coverage for an account. Identify a Billing Addressee. (If you are your own Billing Addressee, you do not need to complete this section and can proceed to the Insurance Information section.)

Full Legal Name of Billing Addressee *(Last, Suffix, First, Middle)*					
Salutation *(Mrs., Mr., Ms., Miss)*	Birth Date *(Month DD, YYYY)*	Age	Sex	Mayo Clinic Number	Relationship to Patient
Address *(Street, City, State and ZIP)*			Marital Status		Social Security Number
			Home Phone		Cell Phone
			Country		Fax

Billing Addressee Secondary Address *(i.e., summer or winter home)*

Address *(Street, City, State and ZIP)*	Effective From and To Dates *(Month DD, YYYY* to *Month DD, YYYY)*	
	Country	Home Phone

Billing Addressee Employment Information

Employer Name	Occupation	
Employer Address *(Street, City, State and ZIP)*	Employment Status	
	Country	Work Phone

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Mayo Clinic Number *(if known)*	Patient Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Insurance Information

Provide the information that appears on your insurance card(s), and if you have access to a copy machine, include **photocopies** of the front and back of your insurance card(s).

☐ Check this box if you do not have insurance or do not plan to use your insurance benefits. Proceed to last page to sign this form.

Liability Information (if applicable)

Is your illness, injury, or condition due to one of the following: ☐ Work-Related ☐ Motor Vehicle ☐ Other Liability Note: If your liability policy information is not listed on this form, add it in the Unlisted Insurance section	Area of body injured	
	Date of Incident *(Month DD, YYYY)*	State/Province incident occurred

Medicare Information (if applicable)

Beneficiary Name *(as shown on Medicare card)*		
Medicare Claim Number (including alpha letter(s))		Check as appropriate: ☐ Medicare is primary coverage. ☐ You or your spouse have insurance which may be primary over Medicare. ☐ You signed Medicare benefits over to a Medicare Advantage Plan. Note: Include your Medicare Advantage Plan policy information on this form.
Effective Date for Hospital *(Part A)* *(Month DD, YYYY)*	Effective Date for Medical *(Part B)* *(Month DD, YYYY)*	

Government Assistance Program *(such as Medicaid, AHCCCS, MN Healthcare Programs, etc.)*

Are you covered by a Government Program, such as Medicaid, AHCCCS, MN Healthcare Programs, etc.? ☐ Yes ☐ No			
Program Name	Program's Street Address	Follow-Up Phone	
Recipient or Certificate Identification Number	City	State	ZIP

Insurance

Insurance Company Name		1. Is this your primary insurance? ☐ Yes ☐ No ☐ Not Sure 2. Is this an HMO *(Health Maintenance Organization)*? ☐ Yes ☐ No 3. Indicate insurance plan *(check one)*: ☐ Medical and Hospital ☐ Hospital Only ☐ Medical Only 4. Identify specific coverage if other than general medical: ☐ Disability ☐ Motor Vehicle *(Auto)* Accident ☐ Dental Only ☐ Other Liability ☐ Workers' Compensation ☐ Cancer Only ☐ Mental Health
Claims Submission Address *(Street, City, State and ZIP)*		
Follow-up Phone	Date coverage began *(and ended if applicable)* *(Month DD, YYYY - Month DD, YYYY)*	

Precertification/Review Agency Name and Phone	Subscriber Birth Date *(Month DD, YYYY)*	Subscriber Identification Number
Subscriber Name	Subscriber Relationship to Patient	Group and/or Claim Number
Subscriber Social Security Number	Patient Identification Number	Group Name and/or Subscriber's Employer

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Mayo Clinic Number *(if known)*	Patient Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Insurance

Insurance Company Name		1. Is this your primary insurance? ☐ Yes ☐ No ☐ Not Sure 2. Is this an HMO *(Health Maintenance Organization)*? ☐ Yes ☐ No 3. Indicate insurance plan *(check one)*: ☐ Medical and Hospital ☐ Hospital Only ☐ Medical Only 4. Identify specific coverage if other than general medical: ☐ Disability ☐ Motor Vehicle *(Auto)* Accident ☐ Dental Only ☐ Other Liability ☐ Workers' Compensation ☐ Cancer Only ☐ Mental Health
Claims Submission Address *(Street, City, State and ZIP)*		
Follow-up Phone	Date coverage began *(and ended if applicable)* *(Month DD, YYYY - Month DD, YYYY)*	
Precertification/Review Agency Name and Phone	Subscriber Birth Date *(Month DD, YYYY)*	Subscriber Identification Number
Subscriber Name	Subscriber Relationship to Patient	Group and/or Claim Number
Subscriber Social Security Number	Patient Identification Number	Group Name and/or Subscriber's Employer

Insurance

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Claims Submission Address *(Street, City, State and ZIP)*		
Follow-up Phone	Date coverage began *(and ended if applicable)* *(Month DD, YYYY - Month DD, YYYY)*	
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Insurance Company Name		1. Is this your primary insurance? ☐ Yes ☐ No ☐ Not Sure 2. Is this an HMO *(Health Maintenance Organization)*? ☐ Yes ☐ No 3. Indicate insurance plan *(check one)*: ☐ Medical and Hospital ☐ Hospital Only ☐ Medical Only 4. Identify specific coverage if other than general medical: ☐ Disability ☐ Motor Vehicle *(Auto)* Accident ☐ Dental Only ☐ Other Liability ☐ Workers' Compensation ☐ Cancer Only ☐ Mental Health
Claims Submission Address *(Street, City, State and ZIP)*		
Follow-up Phone	Date coverage began *(and ended if applicable)* *(Month DD, YYYY - Month DD, YYYY)*	
Precertification/Review Agency Name and Phone	Subscriber Birth Date *(Month DD, YYYY)*	Subscriber Identification Number
Subscriber Name	Subscriber Relationship to Patient	Group and/or Claim Number
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Authorizations

Authorization to Release Medical Information*

I authorize Mayo Clinic**, its employees or agents, to release all medical information as necessary to:

- All insurance carriers, health-plan administrators, or any other payers, including the Centers for Medicare & Medicaid Services (CMS), their agents or review agencies for processing health care claims;
- The person(s) I designate as my Billing Addressee 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; and
- My other health care providers for treatment or payment purposes.

Authorization to Assign Benefits and Release Information to Mayo Clinic

I authorize my insurance carrier, health-plan administrator or any other payer 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 that Mayo Clinic reserves the right to refuse or accept assignment of medical benefits. If my health care plan will not allow direct payment to Mayo Clinic or if Mayo Clinic chooses not to accept assignment of medical benefits, I agree to immediately forward to Mayo Clinic all health care payments I receive for services provided by Mayo Clinic. I also authorize Mayo Clinic, its employees or agents, to contact my insurance carrier, health-plan administrator or any other payer, their agents or review agencies, to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s). I further authorize my insurance carrier, health-plan administrator or any other payer, their agents or review agencies, to release such information to Mayo Clinic, its employees or agents.

Service Terms

Statement of Financial Responsibility

I acknowledge I am responsible for all charges for services provided to me, 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), a workers' compensation policy, or any other payer.

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.

Medical Information within Mayo Clinic

I acknowledge my medical information may be shared for purposes of treatment, payment, and health care operations with Mayo Clinic in Arizona, Florida and Rochester; and all affiliated clinics, hospitals, and entities.

Use of Cell Phone

I agree Mayo Clinic may use an automated telephone dialing system to contact the cellular telephone number(s) that I provide to Mayo Clinic for appointment and payment purposes.

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 *(Required)*	**Signature Date** *(Required)* *(Month DD, YYYY)*

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

Signature Required

ATTENTION: Please sign and date this page.

* 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, Mayo Clinic refers to Mayo Clinic in Arizona, Florida and Rochester and all affiliated clinics, hospitals, and entities.

Internal Use: Route to Registration

Print