Patient Enrollment Form

PrimeCare Venice
1531 S. Tamiami Trail, suite 703
Venice, FL 34285
phone: 941-676-3440
fax: 941-303-5552
Primecarevenice.com

Patient Name:	
Date of Birth:	
Social Security Number:	
Facility Location/Room Number:	
Emergency Contact:	
Relationship to Patient:	
Emergency Telephone Number:	

Medicare ID # (photo ID required)	
Primary Plan Name:	
Policy/Group #	
Secondary Plan Name:	
Policy/Group #	

<u>Personal Representative (Healthcare Decision Maker):</u> Provide a copy of health Care Directive, or POA paperwork.

Name: ______________________________

Relationship to Patient: _______________

Phone Number: _____________________Email Address:____________________

N/A ____ Patient does not have a Power of Attorney (POA) on file.

Consent for Services

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Patient Full Name: ______________________________Date of Birth:____/____/______
Facility Name/Rm number:________________________

By signing this form I give authorization to PrimeCare Venice, LLC to provide all necessary Primary care related services including medical evaluation and treatments, preventative care services and related procedures which are deemed appropriate by my health care Provider and associated staff. I understand that all of my Primary care services will now be completed through my PrimeCare Venice Provider.

I understand that I am allowing PrimeCare Venice to enroll me in the Chronic Care Management (CCM) program, which includes regular visits and care coordination for my chronic health care needs. CCM series will be billed appropriately through my insurance and will include the associated deductible and copay for my plan. I have the right to end CCM services at any time upon given verbal or written notification.

I have been provided a copy of my Privacy Practice Rights and have been given the opportunity to read through them before signing this consent. I will be given a copy of my Privacy Rights at any time and can contact PrimeCare Venice for further information. I give consent to the use and discloser of my personal health information to be utilized appropriately as described in the Notice of Privacy Practices.

I authorize PrimeCare Venice to bill my insurance plan and receive payments for services directly provided to me. I give consent to use and disclose my health information for payment purposes and understand that I reserve the right to refuse services and treatment at any time upon verbal or written notification. My PrimeCare Venice healthcare Provider has the right to discharge or discontinue services after 30 days of receiving written notification.

Patient (or legal representative) signature:_______________________________date_________

Relationship to patient:__________________________

Email Address:________________________________

ddMedical Records Request Form

PrimeCare Venice
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Patient Information:

Patient Name:_________________________Date of Birth_______________

Facility Name:_________________________________

Address:________________________City________________State_____Zip_________

Phone Number:______________________

By signing this form, I am authorizing the voluntary release of the requested medical information including past records, labs/imaging, consultation visit notes, hospital and emergency room records, operative reports, and any pertinent medical and insurance information to aide in my continued care and payment services to PrimeCare Venice, PO box 1362 Venice, FL 34284. Records can be faxed to the following: 941-303-5552

I understand that my records are confidential and cannot be disclosed without my written permission. I have the right to refuse request, to revoke this authorization in writing to PrimeCare Venice. I have the right to receive a copy of this authorization. This consent will not expire unless I chose to write in a specific date of expiration here:____________

Patient (or legal representative) signature:________________________________date_________

Relationship to patient:___________________________