MAYO CLINIC

# *Executive Health Program Registration - Corporate*

Reset

Print

Number (above) and Name

Have you ever made an appointment or been previously seen at Mayo Clinic in Rochester or Mayo Clinic in Jacksonville?
❑ Yes ❑ No

Title: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. ❑ Other _____

Name _____

Permanent Address _____

City _____ State _____ Zip Code _____

Telephone No. _____

Where are you staying locally? _____ Telephone No. _____

Dates you will be at this address _____

Date of Birth _____ Sex ❑ Male ❑ Female Social Security No. _____

Occupation _____ ❑ Retired

Employer/Payer _____ Telephone No. _____

Address _____

City _____ State _____ Zip Code _____

Name of payer if other than employer _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Name and address of spouse or nearest living relative ❑ (check if same)

Name _____ Relationship _____

Address _____ Telephone No. _____

# *Patient Information and Mayo Clinic Authorizations and Service Terms*

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

## 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 or claim (including personal injury claims) related to or arising from health care services that I receive at Mayo Clinic that is not resolved by mutual agreement is subject to the exclusive jurisdiction of the appropriate court in the state where the disputed services were received, and the law of that state, respectively: Arizona, Florida or Minnesota. 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:** This is a legal document. Please read carefully. 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)*** ☐ **Surrogate**
- **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)*** | **Date of Signature** *(Required) (Month DD, YYYY)* |
|---|---|
| | |

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

**ATTENTION: Please sign and date this page and return ALL pages of the form.**

* 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.