



PATIENT REGISTRATION FORM

DATE: _____

HOME TELEPHONE: _____

PATIENT INFORMATION

Last, First, and Middle Name: _____ Male Female

Social Security Number: _____ Birth Date: _____ Age: _____

Home Address (include city, state, zip) _____

Parent/Guardian: _____ Social Security #: _____

Parent/Guardian Work Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Relationship: _____ Birth Date: _____ Male Female

2nd Parent/Guardian: _____ Social Security #: _____

Parent/Guardian Work Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Relationship: _____ Birth Date: _____ Male Female

Emergency Contact: _____ Telephone #: _____

How did you hear about our facility? Search Engine (Google, Yahoo Bing) Doctor Friend _____

Magazine _____ Drive-By Insurance Provider Welcome Wagon Other _____

INSURANCE INFORMATION

Primary Insurance: _____

Primary Insurance Address: _____

Primary Insurance ID #: _____ Group #: _____

Subscriber/Guarantor Name: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance: _____

Secondary Insurance Address: _____

Secondary Insurance ID #: _____ Group #: _____

Subscriber/Guarantor Name: _____ DOB: _____

Relationship to Patient: _____

INSURANCE AUTHORIZATION ASSIGNMENT AND OFFICE POLICY

I request that payment of authorized Medicaid/Other Insurance company benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Regarding Non-Participating Insurances: It is your responsibility to understand your policy's benefits regarding out of network services. The bill is your responsibility and is due at the time of services, unless prior arrangements have been made. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract. As a courtesy, our office will submit billing to your insurance.

Regarding Non-Participating Insurance's "Usual and Customary Rates": Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our areas. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Billing Policy: Due to the large number of problems we have had with billing, please note the following office policy: **This office will submit ONE initial bill and ONE appeal for services rendered. If payment is denied or held-up for ANY reason after that you will be personally billed.** We will continue to provide any necessary paperwork for you to pursue insurance reimbursement on your own.

Returned Check Fee: \$30.00

Thank you for understanding our office policy. Please feel free to let our billing office know if you have any questions. Individualized payment plans are available.

I HAVE READ THE ABOVE OFFICE POLICY AND COMPLETED THE PATIENT REGISTRATION FORM. I AGREE AND UNDERSTAND ITS TERMS.

Signature of patient or responsible party

Date