Creekside Family Practice

REGISTRATION

PATIENT INFORMATION		
Last Name	First Name	Middle
Birthdate	Sex ☐ Male ☐ Female ☐ Other	Social Security No.
Street Address/City/State/Zip		
Primary Phone No.	Secondary Phone No.	Work Phone No.
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated	E-mail Address	
Race ☐ Caucasian ☐ African American ☐ Asian American ☐ Hispanic ☐Other		
Ethnicity ☐ Hispanic/Latin American ☐ Non-Hispanic/Latin American	Language	
Employer Name	Employer Address/City/State/Zip	
Emergency Contact Name	Emergency Contact Phone	Relationship of Emergency Contact
		Who should we thank for referring you to our practice?
Our practice prescribes medication electronically. Please list your preferred pharmacy.		
Pharmacy Name & Address	Pharmacy Phone No.	
INSURANCE INFORMATION		
Primary Insurance	Primary Insurance Phone No.	
Policy No.	Group No.	
Policy Holder	Social Security No.	Date of Birth
Secondary Insurance	Secondary Insurance Phone No.	
Policy No.	Group No.	
Policy Holder	Social Security No.	Date of Birth
ASSIGNMENT AND RELEASE		
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Creekside Family Practice PLLC all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.** I authorize the use of this signature on all insurance submissions. I, the patient, give consent for treatment.		
Patient/Guardian Signature	Relationship	Date

TURN OVER TO OTHER SIDE

Creekside Family Practice

POLICIES

Initials	
	I hereby assign ail medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Creekside Family Practice, PLLC for medical services rendered to myself, regardless of my insurance benefits. I understand that I am responsible for any amounts not covered by insurance.
	I understand that it is my responsibility to pay any copay, deductible, or co-insurance at the time of service, and any balance not paid by my insurance is to be paid within a reasonable period of time, not to exceed 60 days.
	Creekside Family Practice has provided me a copy of the Notice of Privacy Practice. I understand I may also find it on the home page located at www.creeksidefamilvpractice.com.
	I understand that Dr. Qureshi has access to medical records at some local affiliations/hospitals. I authorize him to view records that may assist him with management of my care.
	I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, testing, and any other screening ordered by the doctor or staff.
	I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
	I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full.
	I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.
	If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.
	I understand that I will be charged a **$25 no-show fee** if I do not show up for a scheduled appointment or cancel less than 24 hours of my appointment.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient/Guardian Signature ______________________ Date ______________

Patient/Guardian Name ______________________