A-Z Internal Medicine

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Registration
(Please Print)

Patient Information

E-Mail_____

Name_____
(Last) (First) (MI)

Mailing Address_____

DOB_____Marital Status_____Gender M____F____

Home/Cell Phone _____Work Phone_____

Occupation_____ Employer_____

Emergency Contact_____ Relationship to Patient_____Ph#_____

How did you hear about us? _____

Responsible Party (If other than patient) Relationship to patient _____

Name_____
(Last) (First) (MI)

Mailing Address_____

DOB_____ Marital Status_____

Home/Cell Ph_____Work Ph_____

Gender M___ F___ Occupation: _____Employer:_____

Insurance Information

Primary Ins. Name_____ Secondary Ins.Name_____

Ins. Phone _____ Ins. Phone_____

Group # _____ Group # _____

ID/Policy # _____ ID/Policy # _____

Thank you for selecting A-Z Internal Medicine as your healthcare provider! We appreciate the opportunity to assist you with your health care needs.

All copays and deductibles are due at the time of service. Payment for procedures that are deemed NOT medically necessary is due at the time of service and will NOT be billed to insurance. We accept cash, personal checks, or MasterCard and Visa. THere will be a $35 charge for all returned checks. Your services are filed to your insurance within 2 working days of your visit and payment from your insurance is expected within 45days. If you are not on one of the managed care programs that we are providers for, or this is a third party billing situation, payment is expected at the time of service. We will provide you with a billing statement that contains the necessary information for you to file your insurance claims for reimbursement.

If there is a balance due on your account, monthly statements will be sent. If an account falls over 90days old and there has not been an attempt by the patient or legal guardian to make payment arrangements, or failure to comply with the arranged payment schedule, the account may be turned over to a collection agency.

It is up to you to know your insurance coverage and keep us notified of any changes in your insurance plan. If services are denied by your insurance company as non- covered, you will be responsible to pay for these services.

I consent to treatment for the care of the patient indicated on this form, including ordering and/or performing any necessary diagnostic test. I hereby authorize assignment of all medical insurance benefits to A-Z Internal Medicine for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claims. I also authorize release of information necessary to complete referral to other facilities for additional testing or other doctors for specialized services and care as deemed necessary by my primary physician.

Patient or legal Guardian Signature: _____Date:_____