



PATIENT REGISTRATION

PATIENT NAME _____ REFERRING PHYSICIAN _____
LAST FIRST MIDDLE
 DATE OF BIRTH ____/____/____ GENDER _____ PRIMARY CARE PHYSICIAN _____
 SOCIAL SECURITY # _____ EMAIL ADDRESS _____
 HOME PHONE (____) _____ WORK PHONE (____) _____ MOBILE PHONE (____) _____
 HOME ADDRESS _____

PATIENT'S SPOUSE INFORMATION

SPOUSE NAME _____ DATE OF BIRTH ____/____/____
 GENDER _____ PHONE (____) _____

EMERGENCY INFORMATION

NAME OF SOMEONE NOT LIVING WITH YOU _____ PHONE (____) _____
 ADDRESS _____ RELATIONSHIP _____

INSURANCE COVERAGE INFORMATION

PRIMARY	ID #	GROUP #	SUBSCRIBER'S NAME
SECONDARY	ID #	GROUP #	SUBSCRIBER'S NAME
TERTIARY	ID #	GROUP #	SUBSCRIBER'S NAME

IF YOU HAVE INSURANCE, WE WILL BE GLAD TO HELP YOU FILE FOR ANY BENEFITS TO WHICH YOU ARE ENTITLED. HOWEVER, IT REMAINS THE RESPONSIBILITY OF THE INDIVIDUAL PATIENT TO SETTLE HIS/HER ACCOUNT PROMPTLY. TO HELP US FILE YOUR INSURANCE CLAIM CORRECTLY, PLEASE FILL IN THE ABOVE INFORMATION. WE WILL ALSO NEED A COPY OF YOUR INSURANCE CARD

I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED TO ME BY THIS CLINIC. (IF THE PATIENT IS UNDER 18, THE PARENT/GUARDIAN REQUESTING TREATMENT ASSUMES RESPONSIBILITY OF ALL CHARGES) FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT IF MY ACCOUNT SHOULD EVER REQUIRE ACTION BY A COLLECTION AGENCY OR ATTORNEY IN ORDER TO INSURE PAYMENT, THE FEES CHARGED BY THESE AGENTS MAY BE ADDED TO THE BALANCE DUE AND UNPAID ON MY ACCOUNT. I HEREBY ACKNOWLEDGE AND AGREE TO ACCEPT THESE POLICIES STATED HERE.

SIGNATURE _____ DATE _____

AUTHORIZATIONS

INSURANCE AND/OR MEDIGAP

I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS PHYSICIAN, FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE POLICY. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY, INFORMATION CONCERNING HEALTHCARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFITS.

MEDICARE

I, THE UNDERSIGNED, UNDERSTAND THAT THIS CLINIC ACCEPTS ASSIGNMENTS ON MEDICARE. I AGREE TO BE RESPONSIBLE FOR MY DEDUCTIBLE AND/OR ANY UNCOVERED CHARGES, AS WELL AS, 20% OF THE ALLOWANCE OF COVERED SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THIS PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO "THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS" ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

MEDICAID

I AGREE TO BE RESPONSIBLE FOR ANY SERVICE NOT COVERED BY MEDICAID. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAID BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE DIVISION OF MEDICAID OR ITS FISCAL AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES

SIGNATURE _____ DATE _____