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) ____

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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? _______________________________________

INSURANCE INFORMATION

Primary Insurance: ____

Primary Insurance Address: ____

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Primary Insurance ID #: ________________________ Group #: ____________________

Subscriber/Guarantor Name: ________________________________ DOB: __________

Relationship to Patient: _______________________________

Secondary Insurance: ____

Secondary Insurance Address: ____

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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**