

PATIENT REGISTRATION



Welcome to my practice. I am committed to providing the best, most comprehensive care possible. I encourage you to ask questions. Please assist me by providing the following information. All information is confidential and is released only with your consent.

Patient Name _____ Today's Date _____

Date of Birth _____ Sex _____ Age _____ Parent if Patient a Minor _____

Patient's Social Security # _____ Marital Status: Single () Married () Divorced () Widowed ()

Home Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Home Telephone Number _____ Work Telephone Number _____

Occupation _____ Employed () Student () Retired () Disabled ()

Employer _____

Spouse Name _____ Date of Birth _____ Sex _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home Telephone Number _____ Work Telephone Number _____

Occupation _____ Employed () Student () Retired () Disable ()

Other Healthcare Provider's Name _____

Whom May We Thank for Referring You to Our Practice? _____

NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Nearest Relative (not living with you) _____

Home Telephone _____ Work Telephone _____

INSURANCE INFORMATION

Insurance Company _____ Claim Address _____

Subscriber Name _____ Subscriber DOB _____ Subscriber SS# _____

Insurance ID No. _____ Insurance Group No. _____

Secondary Insurance _____ Claim Address _____

Subscriber Name _____ Subscriber DOB _____ Subscriber SS# _____

Please Read Our Financial Policy Statement and Agreement on Reverse

Financial Policy and Agreement

Thank you for choosing me as your primary care provider. I am committed to providing you with quality and affordable health care. Because some of my patients have had questions regarding patient and insurance responsibility for services rendered, I have been advised to develop this payment policy. Please read it, ask me any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance

- I accept assignment on all insurance plans. As a sole provider of primary care services, I am unable to provide you with insurance billing services. You are responsible for submitting your bill to your insurance company for reimbursement. You are also responsible for payment in full at time of service.
- After you send me a copy of your insurance explanation of benefits, I will write off the amount of my charge that your insurance does not approve and refund that money to you. This is called accepting assignment on your insurance.
- If you are not insured, payment in full is expected at each visit. If you are insured but don't have an up-to-date insurance card, payment in full for each visit is required until I can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Deductibles

All deductibles must be paid at the time of service and are non-refundable. This arrangement is part of your contract with your insurance company.

3. Non-covered services

Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of your visit. These services are not refundable.

4. Proof of insurance

All patients must complete the patient information form before seeing me. I must obtain a copy of a current, valid insurance card to provide proof of insurance. If you fail to provide me with the correct insurance information in a timely manner, you will not be able to collect the insurance write-off refund for your claim.

5. Claims submission

You must submit your own insurance claims. I will assist you in any way I reasonably can to help get your claims paid.

- I will provide you with a copy of your super bill to submit to your insurance company. The superbill will contain all the appropriate CPT codes and ICD-9 codes for insurance claims processing in addition to my professional identification numbers. This is all you need to send to your insurance company for reimbursement.
- Your insurance company may need you to supply certain additional information directly and will contact you if so. It is your responsibility to comply with their request.
- Your insurance company will send payment to you. The insurance payment is your reimbursement for my services that you paid for at time of service.
- To receive the insurance assignment write-off refund from me, you must send a copy of the insurance explanation of benefits. Upon my receipt of the explanation of benefits, I will write off the difference between the visit charge and the amount the insurance company approves. That is the amount that I will refund to you.
- Sometimes the insurance companies will approve one amount but pay another. I will only use the approved amount, not the paid amount, to calculate the insurance assignment write-off refund.
- Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; I am not party to that contract.

6. Coverage changes

- If your insurance changes, please notify me before your next visit so I can make the appropriate changes to help you receive your maximum benefits.
- If your insurance company does not pay your claim in 45 days, the amount paid at time of service will stand and no insurance write-off refund will be issued unless special arrangements are made in advance of the 45 days.

7. Nonpayment

- If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will be accepted only if negotiated in advance.
- Please be aware that if a balance remains unpaid, I may be obligated to refer your account to a collection agency.

8. Missed appointments

I will respect and value your time and keep all appointments in a timely manner and expect you will extend the same to me.

- My policy is to charge for missed appointments not canceled within a reasonable amount of time, at least 24 hours in advance, unless circumstance prevents this. You must communicate as soon as possible. Charges will be your responsibility and billed directly to you. Please help me to serve you better by keeping your regularly scheduled appointment.

My practice is committed to providing the best treatment to my patients. *My fees represent usual and customary charges for our area.* Thank you for understanding my payment policy. Please let me know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party _____ **Date** _____