Associated Physicians, LLP

PATIENT REGISTRATION FORM

Date: _____ Physician Name: _____ Account No: _____

Have you or any member of your family been seen by one of our physicians before? ❑ Yes ❑ No

If yes, please list name of patient(s): _____

How did you hear about us? ❑ Friend/Family ❑ Radio ❑ TV ❑ Internet ❑ Newspaper/Magazine ❑ Other: _____

PATIENT NAME: _____ SSN: _____ Sex: ❑ M ❑ F

Last First MI

Date of Birth (DOB): _____ Age: _____ Former Names: _____

Home Address: _____ Home Phone: (_____) _____

City/State/ZIP: _____ Work Phone: (_____) _____

Email: _____ Cell Phone: (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other ❑ Life Partner ❑ Unknown

Preferred Language: _____ Race/Ethnicity _____

Primary Care Physician: _____

EMPLOYMENT STATUS: ❑ Full-Time ❑ Part-Time ❑ Unemployed ❑ Retired ❑ Self Employed ❑ Full-Time Student ❑ Part-Time Student

Patient's Employer: _____ Work Phone: (_____) _____

Occupation: _____ Retirement Date: _____

RESPONSIBLE PARTY:

Name: _____

Relationship: ❑ Self ❑ Spouse ❑ Parent

Address (if different than above): _____

City/State/ZIP: _____

SSN: _____ Date of Birth: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Employer: _____

If patient is a minor, are parents: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married

Parent responsible for providing child's insurance:

_____

Parent responsible for payment of medical expenses not covered by insurance: _____

EMERGENCY CONTACT #1

Name: _____

Relationship to Patient: _____

Address (if different than above): _____

City/State/ZIP: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

EMERGENCY CONTACT #2

Name: _____

Relationship to Patient: _____

Address (if different than above): _____

City/State/ZIP: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

ACCIDENT/INJURY: Is your visit due to a work-related injury? ❑ Yes ❑ No Motor vehicle accident? ❑ Yes ❑ No

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INSURANCE INFORMATION – Please present insurance cards and photo ID for copying and complete the following:

Primary Insurance Company: _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Group No: _____

Subscriber Address: _____ City/State/Zip: _____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Policy Effective Date: _____ Subscriber's Employer: _____

Secondary Insurance Company: _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Group No: _____

Subscriber Address: _____ City/State/Zip: _____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Policy Effective Date: _____ Subscriber's Employer: _____

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MEDICARE LIFETIME AUTHORIZATION
(Complete if applicable)

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of medical information about me to release my health information to the Social Security Administration or its intermediaries or carriers to obtain reimbursement for the provision of health care services. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Associated Physicians, LLP and authorize Associated Physicians, LLP to submit a claim to Medicare for payment for me.

Medicare No: _____ Medicare Part B Effective Date: _____

Patient Signature*: _____ Date: _____

* If this authorization is signed by a representative of the patient, please complete the following:

Representative's Name: _____

Patient is: ____ Minor ____ Incompetent ____ Disabled ____Deceased

Legal Authority: ____ Parent of Minor ____ Legal Guardian ____ Power of Attorney ____Next of Kin

PAYMENT AND BILLING POLICY

We appreciate that you have entrusted us with your healthcare. Because healthcare benefits and coverage options have become increasingly complex, it is your responsibility to know your insurance benefits (i.e. copays, coinsurance, deductibles, preferred providers/hospitals, referrals, preauthorizations, recertifications, limits on outpatient charges, non-covered services, etc.). Your health plan determines your coverage, requirements, and limits to your coverage. We will do our best to assist you with understanding your proposed treatment and in answering any insurance questions you may have.

You, as the patient or responsible party, are responsible for all fees, copays, coinsurance, and/or deductibles regardless of insurance coverage. As a courtesy, we will file your claims to your insurance carrier. In the event your insurance company has not paid the charges within 60 days, you and/or the responsible party will be responsible for the balance due. You will only receive a statement from us after your insurance carrier has responded to your claim. Payment is due upon receipt of statement. It is also your responsibility to obtain referrals from your primary care provider when necessary. If the referral is not obtained before the visit, the patient and/or responsible party will be liable for payment in full at the time of the visit. If we are unable to obtain payment within a reasonable amount of time, we will place your account with a collection agency and you may liable for additional expenses.

Self-pay patients will be asked for a portion of their balance at the time of service. Payment arrangements can be made, if necessary, on the remaining balance. We accept cash, personal checks, MasterCard and Visa.

We understand that financial problems arise from time to time. Let us know if you need to arrange a payment program to pay your balance in monthly installments. Our business office staff will gladly assist you with these arrangements.

I have fully read and understand the above statement of payment policy. I hereby assign to Associated Physicians, LLP any benefits paid on my behalf. I authorize Associated Physicians, LLP to release my health information to obtain reimbursement for the provision of health care services. I understand that Associated Physicians, LLP does not accept partial payments made by insurance carriers as full payment for the services rendered, and I will be responsible for any charges not covered by insurance.

I authorize the providers to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the provider and I consent to care by such provider. I understand these services are voluntary and that I have the right to refuse these services.

I understand that this authorization is valid until I choose to revoke it.

Patient /Subscriber Signature: _____ Date: _____

Witness Signature: _____ Date: _____