

PLEASE PRINT

PATIENT REGISTRATION

FORM 1001-REV. 11/05

PLEASE COMPLETE ALL WHITE AREAS

PATIENT INFORMATION

The person seeing the doctor.

|                    |  |                |                                  |
|--------------------|--|----------------|----------------------------------|
| TODAY'S DATE       |  |                |                                  |
| PATIENT NUMBER     |  |                |                                  |
| LAST NAME          | FIRST NAME & INITIAL   |                |                                  |
| ADDRESS LINE 1     |  |                |                                  |
| ADDRESS LINE 2     |  |                |                                  |
| CITY               | STATE  | ZIP            |                                  |
| HOME PHONE         | CELL PHONE   | E-MAIL ADDRESS |                                  |
| SEX                | MARITAL STATUS (M/S)   | DATE OF BIRTH  | M.D. REQUESTING YOUR APPOINTMENT |
| PATIENT'S S.S. NO. | IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW<br><input type="checkbox"/> PATIENT <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> PROVIDER BOOK <input type="checkbox"/> OTHER |                |                                  |
| PATIENT'S EMPLOYER |  |                |                                  |
| EMPLOYER ADDRESS   |  |                |                                  |
| CITY               | STATE  | ZIP            |                                  |
| EMPLOYER PHONE     | EXT.   |                |                                  |

GUARANTOR

Person responsible for all unpaid balances on this account.

|                       |                      |                |                |
|-----------------------|----------------------|----------------|----------------|
| RESP. PARTY LAST NAME | FIRST NAME & INITIAL |                | RELATIONSHIP   |
| ADDRESS               |                      |                |                |
| CITY                  | STATE                | ZIP            | E-MAIL ADDRESS |
| HOME PHONE            | CELL PHONE           | PAGER NUMBER   |                |
| RESP. PARTY EMPLOYER  |                      |                |                |
| EMPLOYER ADDRESS      |                      |                |                |
| EMPLOYER PHONE        | EXT.                 | EMPLOYER FAX # |                |

INSURANCE

List all insurance for which you have a current card. List Medicare or Medicaid first.

|                        |            |  |               |
|------------------------|------------|--|---------------|
| INSURANCE #1 NAME      |            |  | INS. #1 CODE  |
| INSURANCE #1 ADDRESS   |            |  | INS. #1 PHONE |
| POLICYHOLDER LAST NAME | FIRST NAME |  | RELATIONSHIP  |
| CERTIFICATE #          | GROUP NO.  |  | MEMBER NO.    |
| INSURANCE #2 NAME      |            |  | INS. #2 CODE  |
| INSURANCE #2 ADDRESS   |            |  | INS. #2 PHONE |
| POLICYHOLDER LAST NAME | FIRST NAME |  | RELATIONSHIP  |
| CERTIFICATE #          | GROUP NO.  |  | MEMBER NO.    |
| INSURANCE #3 NAME      |            |  | INS. #3 CODE  |
| INSURANCE #3 ADDRESS   |            |  | INS. #3 PHONE |
| POLICYHOLDER LAST NAME | FIRST NAME |  | RELATIONSHIP  |
| CERTIFICATE #          | GROUP NO.  |  | MEMBER NO.    |

|               |  |
|---------------|--|
| NAME          |  |
| RELATIONSHIP  |  |
| DAYTIME PHONE |  |

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES:**

DATE \_\_\_\_\_

INITIAL \_\_\_\_\_

**Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail**

I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Telephone Number \_\_\_\_\_

INITIAL \_\_\_\_\_

**CONSENT TO TREAT:** I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL \_\_\_\_\_

**MEDICARE CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL \_\_\_\_\_

**FINANCIAL AGREEMENT:** I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. Patient agrees to pay the Patient Due Balance on each Monthly Statement, in full within 15 days of that Statement.

INITIAL \_\_\_\_\_

**CONSENT TO DISCUSS MEDICAL INFORMATION:** I give consent to my physician and/or physician staff to discuss medical information with my spouse , my parents (guardian) , other: Name \_\_\_\_\_

INITIAL \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

DATE \_\_\_\_\_

**ADVANCED DIRECTIVE**

1. Do You Have A Living Will? Yes \_\_\_\_\_ No \_\_\_\_\_  
A copy may be needed for your chart.  
A Copy Was Received By This Office. Date \_\_\_\_\_

2. Have You Appointed A Health Care Representative? Yes \_\_\_\_\_ No \_\_\_\_\_ **Read and Sign Below**  
I give my consent and authorization for this person or persons I list below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also give consent, and authorization for the person, or persons to be notified any time I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.

Name of your Health Care Representative \_\_\_\_\_ Date \_\_\_\_\_

Name of your Health Care Representative \_\_\_\_\_ Date \_\_\_\_\_

Signed By: \_\_\_\_\_ Date \_\_\_\_\_

Witnessed By: \_\_\_\_\_ Date \_\_\_\_\_

3. Have You Given Anyone Your Power Of Attorney? Yes \_\_\_\_\_ No \_\_\_\_\_ **Please list below**  
A copy may be needed for your chart.  
A Copy Was Received By This Office. Date \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**Fishers Family Care**  
**Financial Policy**

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. This will remain in effect for all services rendered during your time as a patient at Fishers Family Care.

**Primary Insurance-**

We will file claims with your insurance upon the submission of proof of insurance (insurance card indicating coverage, identification number and group number). **In the event you have insurance coverage but cannot provide documentation; payment is due at the time of service.** Upon receipt of the insurance card, we will submit the health insurance claim form indicating your payment at time of service. If you have an insurance co-pay, this is due at the time services are rendered.

We cannot bill an insurance company unless you provide us with insurance information. Your insurance policy is a contract between the patient and the insurance company. We are not a part of that contract. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance plan. You may be asked to sign a date/procedure specific waiver if we believe that your insurance may deny payment for that service.

**Secondary Insurance-**

Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to you and due upon receipt.

**Insurance Participation-**

**You are responsible to know if the physician is participating in your insurance network.** Fishers Family Care will not be responsible for charges incurred due to the physician being out of network.

**Patient Financial Responsibility-**

If no insurance is to be filed, or if we are not a participating provider in your insurance plan, **full payment is expected.** If necessary we can set up a payment plan. Payment arrangements will be made with a signed Payment Agreement. Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, check, and credit cards.

**Minor Patients:**

The adult accompanying a minor or the parent(s) or guardian(s) of the minor are responsible for full payment. Children under the age of 18 will require a signature of a responsible party on the registration form.

**Workers compensation-**

Workers compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and the workers compensation form must be completed.

**Motor Vehicle Accidents-**

**Payment of visit for auto accidents will be due at the time of service.** Fishers Family Care does not file insurance claims to auto insurance carriers. Fishers Family Care will provide any information requested from the auto insurance carrier upon the patients signature on a release of records form.

**Missed Appointments-**

Unless cancelled at least 24 hours in advance, **you may be charged \$25.00 as a missed appointment fee.** If you are more than 15 minutes late, you will have to re-schedule and may be charged for the cancellation.

**Self Pay Balances-**

Self pay balance must be paid in full prior to your next visit provided a payment arrangement is not in place.

**Returned Checks-**

Checks returned from the bank will be charged back to your account. The amount of the banks returned check fee will also be charged to your account.

**Method of Payment-**

Acceptable methods of payment are cash, check, and credit cards

**I have read the Financial Policy. I understand and agree to this Financial Policy.**

\_\_\_\_\_ X \_\_\_\_\_  
Patient Name Signature of patient or responsible party Date

**My Physician is:** \_\_\_\_\_