Associated Physicians
Devoted Physicians, Trusted Care.

PATIENT REGISTRATION FORM

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): _____
Date: _____ Physician Name: _____ Account No: _____

PATIENT NAME: _____ SSN: _____ Sex: ❑ M ❑ F
Last First MI

Former Names: _____ Date of Birth (DOB): _____ Age: _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Home Phone: (_____) _____
Home Address: _____ Work Phone: (_____) _____
City/State/ZIP: _____ Cell Phone: (_____) _____

EMPLOYMENT STATUS: ❑ Employed ❑ Self-Employed ❑ Retired ❑ Unemployed ❑ Full-Time Student ❑ Part-Time Student
Patient's Employer: _____ Work Phone: (_____) _____
Retirement Date: _____

SPOUSE'S NAME: _____ SSN: _____ DOB: _____
Spouse's Employer: _____ Work Phone: (_____) _____

RESPONSIBLE PARTY: _____ Relationship: ❑ Self ❑ Spouse ❑ Parent
Address (if different than above): _____
If patient is a minor, parents are: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married
Responsible Party is: ❑ Joint custodial parent/guardian ❑ Sole custodial parent/guardian

Parent A: _____ Parent B: _____
Parent A SSN: _____ Parent B SSN: _____
Parent A Date of Birth: _____ Parent B Date of Birth: _____
Parent A Home Phone: _____ Parent B Home Phone: _____
Parent A Work Phone: _____ Parent B Work Phone: _____
Parent A Cell Phone: _____ Parent B Cell Phone: _____
Person responsible for: **1)** Providing child's insurance: _____ **2)** Payment of medical expenses _____

EMERGENCY CONTACT (not living with you): _____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

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

INSURANCE INFORMATION – Please present insurance cards and photo ID for copying and complete the following:
Primary Insurance Company: _____ Phone: (_____) _____
Subscriber/Member No: _____ Group No: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Policy Effective Date: _____ Subscriber's Employer: _____
Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____
Secondary Insurance Company: _____ Phone: (_____) _____
Subscriber/Member No: _____ Group No: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Policy Effective Date: _____ Subscriber's Employer: _____
Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

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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 ID#: _____ 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. NOTE: Statements do not generate for account balances under $10.** 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 be 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, Visa, Discover, Flex plan cards, Apple and Google Pay.

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.

☐ **IF PATIENT IS A MINOR, PLEASE UNDERSTAND THE FOLLOWING:**

Please check box if applicable, that either custodial parent/ guardian may sign this authorization going forward without changing the guarantor account unless requested and it is authorized that our office may discuss any billing related topics with either custodial parent/guardian, unless otherwise revoked.

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

Patient /Subscriber Signature: _____ Date: _____

Witness Signature: _____ Date: _____