

PATIENT REGISTRATION

Please fill in all portions.

Date _____

Name _____
Last First MI

Phone # (Home) _____ (Day) _____

Address _____ City _____

State _____ Zip _____ E-Mail: _____

Sex Male Female Age _____ Date of Birth _____

Occupation _____ Employer _____

Employer's address _____

Spouse's name (or parent/guardian for minor) _____

Spouse's employer _____

Emergency Contact _____ Phone # _____

CLINIC POLICY REQUIRES PAYMENT AT THE TIME SERVICES ARE RENDERED. WE ACCEPT VISA/MC, PERSONAL CHECKS, AND CASH. WE WILL BE GLAD TO BILL YOUR PRIMARY INSURANCE FOR YOU IN MOST INSTANCES; HOWEVER, YOU ARE RESPONSIBLE FOR YOUR PORTION (DEDUCTIBLES/COPAYS) AT THE TIME OF YOUR VISIT. ***IF YOU MISS YOUR APPOINTMENT OR CANCEL LESS THAN 24 HOURS IN ADVANCE OF YOUR APPOINTMENT, WE CHARGE A FEE OF 50 DOLLARS. IF A NEW PATIENT APPOINTMENT OR A PHYSICAL EXAM APPOINTMENT IS MISSED OR CANCELED LESS THAN 24 HOURS, IN ADVANCE OF YOUR APPOINTMENT TIME YOU WILL BE BILLED THE FULL AMOUNT OF THE VISIT. PLEASE BE ADVISED AN INTEREST CHARGE OF 1.5% PER MONTH, COMPOUNDED, WILL BE ADDED TO ANY BALNCE OWING BEYOND 30 DAYS.***

Do you have insurance that covers our services? Yes No

Insurance company _____ Phone # _____

Subscriber's name _____ Relationship to patient _____

Date of Birth _____ ID # _____ Group # _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if I suspend or terminate my care and treatment, any fees incurred by me will be immediately due and payable. Furthermore, any charges, fees, or court cost incurred as a result of collection efforts will be added to my account balance. I hereby authorize the provider to release all necessary information to secure the payment of benefits.

Patient's Signature _____

Parent or Guardian's Signature _____

Date _____