



PATIENT PRE-REGISTRATION FORM

PATIENT'S NAME: \_\_\_\_\_ SEX M/F

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ (AGE) \_\_\_\_\_

PRIMARY INSURANCE CO: \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_

ID# \_\_\_\_\_ GRP # \_\_\_\_\_

INSURED'S NAME/GUARANTOR: \_\_\_\_\_

SECONDARY INSURANCE CO: \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_

ID#: \_\_\_\_\_ GRP# \_\_\_\_\_

INSURED'S NAME/GUARANTOR \_\_\_\_\_

ON JOB CLAIM: YES / NO INJURY DATE: \_\_\_\_\_

CAUSE OF INJURY: \_\_\_\_\_

DATE OF NEXT APPT. WITH YOUR PHYSICIAN: \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I Authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURANCE. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary and secondary insurance company as a courtesy to you after receiving a copy of your current insurance card. If you have a balance on your account, we will send you a monthly statement after your insurance has been billed. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance which may include the full amount of charges if the insurance company denies coverage. If your insurance company requires a referral and/or preauthorization, your are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from the insurance company.

FINANCE CHARGE AND PAST DUE ACCOUNTS. A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of one point zero (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent. If your account becomes past due, we will take all necessary steps to collect the account balance which may include referral to an independent collection agency.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_