

PATIENT REGISTRATION

Name: _____ **Birthplace:** _____ **Age:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **SS#:** _____ **Driver's License:** _____
Employer: _____ **Occupation:** _____
Work Address: _____ **City:** _____ **Zip:** _____
Work Phone: _____ **Emergency Contact:** _____ **Phone:** _____

Spouse or Guarantor: _____ **Relationship:** _____
Address (Same): _____
SS#: _____ **Birth Date:** _____
Home Phone (Same): _____ **Work Phone:** _____
Employer: _____ **Occupation:** _____
Work Address: _____ **City:** _____ **Zip:** _____

Insurance (primary): _____ **Subscriber #:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Adjuster:** _____
Policy ID's (Group, Certif., Policy #'s): _____ **HMO? Y N**

Insurance (secondary): _____ **Subscriber #:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Adjuster:** _____
Policy ID's (Group, Certif., Policy #'s): _____ **HMO? Y N**

CREDIT AND COLLECTION POLICY

Payment for all services rendered is expected at the time of service. You will be issued a receipt at the time of payment that contains all of the information needed by Insurance companies for consideration of reimbursement. As a courtesy, we will assist you in completing your claims forms, however you must submit the form. HMO patients must obtain authorization from their primary care physician for EVERY visit or assume responsibility for payment. Visa, MasterCard, American Express and Discovery credit cards may be used for payment if so desired. Overdue accounts are subject to interest charges at 30 days. At 60 days, overdue accounts are referred to TRW Credit Services. This is a national Credit Service. Both credit delinquencies and past due account management is handled by outside sources. Delinquent accounts reports WILL adversely impact the credit ratings of affected individuals.

Insurance Submission Authorization: _____
 Claim submission on my behalf requested. (Required signature for insurance submission)

Medical Problem: _____
Referred By: _____