

PATIENT REGISTRATION FORM

PATIENT NAME: _____ DOB: _____ SEX: M F
ADDRESS: _____ SSN: _____
CITY: _____ STATE: _____ ZIP: _____
HOME #:() CELL #:()
EMPLOYER: _____ WORK #:()
REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

Married SPOUSE'S NAME: _____ DOB: _____ SSN: _____
EMPLOYER: _____ WORK #:()
Single Divorced Widowed Separated Partner Minor

PERSON(S) RESPONSIBLE FOR BILL:
NAME: _____ DOB: _____
ADDRESS: _____ SSN: _____
CITY: _____ STATE: _____ ZIP: _____
HOME #:() CELL #:() RELATION TO PATIENT: _____
EMPLOYER: _____ WORK #:()

EMERGENCY CONTACT: _____
HOME #:() RELATION TO PATIENT: _____

FOR MINOR PLEASE COMPLETE THIS SECTION:

FATHER'S NAME: _____ DOB: _____ SSN: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME #:() CELL #:()
EMPLOYER: _____ WORK #:()
MOTHER'S NAME: _____ DOB: _____ SSN: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME #:() CELL #:()
EMPLOYER: _____ WORK #:()
GUARDIAN'S NAME: _____ DOB: _____ SSN: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME #:() CELL #:()
EMPLOYER: _____ WORK #:()

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____
GROUP #: _____ NAME OF POLICY HOLDER: _____
RELATION TO PATIENT: _____ DOB: _____ SSN: _____
POLICY HOLDER EMPLOYER: _____ WORK#:()

SECONDARY INSURANCE: _____ POLICY #: _____
GROUP #: _____ NAME OF POLICY HOLDER: _____
RELATION TO PATIENT: _____ DOB: _____ SSN: _____
POLICY HOLDER EMPLOYER: _____ WORK#:()

Important Notice: In order to submit your claim electronically we must have the DOB of the subscriber.

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAS THE INSURANCE COVERAGE LISTED ON THE REVERSE SIDE OF THIS PATIENT REGISTRATION FORM AND ASSIGN DIRECTLY TO DR. PORTER. ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR MEDICAL SERVICES RENDERED. IF THIS PATIENT IS A MINOR CHILD, I ALSO CERTIFY THAT THE PARTY RESPONSIBLE FOR THIS ACCOUNT HAS GIVEN HIS/HER PERMISSION FOR THE PATIENT TO BE TREATED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR, THE DOCTOR'S BILLING COMPANY OR STAFF TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS EITHER VIA PAPER CLAIM OR ELECTRONICALLY.

RESPONSIBLE PARTY

RELATION TO PATIENT

DATE

MEDICAL AUTHORIZATION

I REQUEST THE PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED TO DR. PORTER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF I HAVE A SECONDARY INSURANCE COMPANY AS I HAVE INDICATED, MY SIGNATURE AUTHORIZES RELEASE OF INFORMATION TO THE INSURER OR AGENCY SHOWN WHETHER SUBMITTED BY PAPER CLAIM OR BY ELECTRONIC MEANS. IN MEDICARE ASSIGNED CASES, THE PROVIDER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE AND CO-PAYMENT AMOUNTS. I ALSO UNDERSTAND THAT SOME SERVICES MAY NOT BE COVERED BY THE MEDICARE PROGRAM AND THAT I AM RESPONSIBLE FOR PAYMENT OF THOSE SERVICES.

MEDICARE RECIPIENT'S SIGNATURE

DATE

WITNESS

MEDICAL ASSISTANCE ASSIGNMENT AND RELEASE

I UNDERSTAND THAT I AM PERSONALLY LIABLE FOR ANY CHARGES NOT COVERED BY MEDICAL ASSISTANCE. I ALSO UNDERSTAND THAT THIS ACCOUNT AND THE CHARGES INCURRED ARE MY RESPONSIBILITY AND IF MY MEDICAL ASSISTANCE COVERAGE IS PENDING, MY ACCOUNT WILL BE TREATED AS A SELF PAY ACCOUNT UNTIL I PRODUCE AN ELIGIBILITY CARD. I FURTHER AUTHORIZE THE BILLING COMPANY/STAFF AND DR. PORTER TO RELEASE TO THE STATE MEDICAL ASSISTANCE PROGRAM MEDICAL INFORMATION NECESSARY TO SECURE PAYMENT.

PATIENT/GUARDIAN SIGNATURE

DATE

NAME AS IT APPEARS ON ID CARD