Select Medicine, P.C.
Patient Registration Form

Patient Name: _____ ☐ Jr ☐ Sr
First Middle Last

Sex: ☐ Male ☐ Female **Date of Birth:** ____/____/____
M D Y

Social Security # _____

Address: _____
Street # Street Name Apt #

_____
City State Zip

Home Phone: (___)_____ **Work #** (___)_____ **Mobile #** (___)_____

Responsible Party: _____ **If Student**: ☐ Full Time ☐ Part Time

Parent/Guardian/ Spouse's Name: _____

Emergency Contact Name: _____**Telephone #** _____ **Relationship** _____

Referred By: _____ **Primary Care Physician**: _____

Policy Holder Information – Primary Insurance:

Primary Insurance Name: _____ **Name of Policy Holder**: _____

Policy Holder's Date of Birth: _____/_____/_____ **Patient's Relationship to Policy Holder**: _____

Social Security # _____

Patient's ID # _____ **Group #** _____

Address: _____ **City/ST**_____ **Zip Code** _____

Home Phone: (_____)_____ **Cell Phone** (_____)_____

Employer Name: _____ **Work Phone** (_____)_____

Policy Holder Information – Secondary Insurance:

Secondary Insurance Name: _____ **Name of Policy Holder**: _____

Policy Holder's Date of Birth:: _____/_____/_____ **Patient's Relationship to Policy Holder**: _____

Social Security # _____

Patient's ID # _____ **Group #** _____

Address: _____ **City/ST** _____ **Zip Code** _____

Home Phone: (_____)_____ **Cell Phone** (_____)_____

Employer Name: _____ **Work Phone** (____)_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

With my consent, Select Medicine, P.C., may use and disclose protected health information (PHI) about me to carry out treatment. Please refer to Select Medicine, P.C., Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Select Medicine, P.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cindy Garraputa, Privacy Officer.

I HEREBY AUTHORIZE THAT MY INSURANCE BENEFITS BE PAID DIRECTLY TO SELECT MEDICINE, P.C. AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

***I hereby authorize my:** □ **Medical Information** □ **Financial Information**

PLEASE CIRCLE IF MEDICAL AND/OR FINANCIAL

Disclosed to _____ **Relationship** _____

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Participating Plans:
Our doctors are participating providers with several health insurance plans. For these insurance plans, all co-payments and/or deductibles are due on the day of your appointment. If your insurance plan notifies us that you are responsible for additional co-payments, co-insurances and/or deductibles, you will be billed.

Non-Participating Plans:
In general, we do not "accept assignment" or bill a health insurance plan with which we do not participate. **You will be expected to pay in full for all services on the date of treatment.**

PAYMENT METHODS: CASH, CHECKS, or VISA/MASTERCARD

Patient or Responsible Party Signature: _____ Date:_____

Reminder: Co-payment is required at the time of your visit.

EFFECTIVE MAY 1, 2008 THERE WILL BE AN ADMINISTRATIVE FEE OF $30.00 FOR ANY NO SHOW APPOINTMENT AND/OR MISSED CO-PAYMENTS.

Reviewed by: _____