Please bring your picture ID, insurance card, and all current medication bottles.

Failure to do so may result in rescheduling your appointment.

PMC Physician Network

PATIENT REGISTRATION FORM

Date: _____/_____/_____

Patients Full Name:_____

(Last) (First) (Middle) (Maiden)

Date of Birth: _____/_____/_____ Social Security #:_____ Marital Status: S M W D

Address:_____

City: _____ State: _____ Zip code:_____

Home Phone: _____Cell Phone: _____ Other number: _____

E-mail Address:_____

Employer: _____ Phone:_____

Spouse's Name: _____Date of Birth: _____/_____/_____Social Sec#:_____

Employer: _____Phone: _____

Emergency
Contact:_____Home #:_____ Work #:_____

(THIS MUST BE COMPLETED)

Complete below for patient's under 18 and/or covered by another's insurance:

Father's Full Name: _____Date of Birth: _____/_____/_____SS#:_____

Address (if different from child):_____

Home phone: _____Employer:_____Phone:_____

Mother's Full Name: _____Date of Birth:_____/_____/_____SS#_____

Address (if different from child's address):_____

City:_____State:_____Zip code:_____

Home #:_____Employer:_____Phone:_____

How did you hear about us? (Please check all that apply)

Insurance _____ Work _____ Website _____ Patient _____ Radio _____ Mailer _____ Family _____

Hospital _____ Physician _____ Friend _____ Newspaper _____ Yellow Pages _____

PMC Physician Network

PATIENT REGISTRATION FORM

INSURANCE INFORMATION:

COMPLETE ONLY IF YOU DO NOT HAVE A CURRENT COPY OF YOUR INSURANCE CARD. BE SURE TO NOTIFY US IF YOUR INSURANCE HAS CHANGED.

Primary Insurance:_____ Effective Date: _____/_____/_____

Member's Name (policy holder): _____ Policy Holder's Date of Birth: ____/_____/_____

Policy Holder's Social Security #: _____ Member ID#:_____

Group #:_____ Employer:_____

Secondary Insurance:_____ Effective Date:_____/_____/_____

Member's Name (policy holder): _____ Policy Holder's Date of Birth: _____/_____/_____

Policy Holder's Social Security # :_____ Member ID #:_____

Group #:_____ Employer:_____

ASSIGNMENT AND RELEASE:

I, the undersigned, assign directly to PMC Physician Network all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

I further authorize PMC Physician Network to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

Financial Agreement:

I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature: _____ Date: _____/_____/_____

Witness: _____ Relationship to Patient: _____

MINOR CHILD CONSENT

I, being the parent/guardian of, _____do hereby request and authorize PMC Physician Network and staff to perform necessary services for my child, including but not limited to x-rays, labs and administration of medications and anesthetics which are deemed advisable by the physician.

Signature:_____ Date: _____/_____/_____

Witness: _____ Relationship to Patient: _____

PMC Physician Network

PATIENT REGISTRATION FORM

⌘**Office Financial Policy:**

We are happy that you selected **PMC Physician Network** for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are financially responsible for all services provided and are expected to pay for services received on the same date that services are rendered. Patients are also responsible for any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship.

⌘**Medicare:**

The office will bill the Medicare intermediary. Patients are responsible for the following:

- $124 annual Medicare Part B deductible
- 20% co-pay of the allowed charge
- any non-covered services
- any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

⌘**Medicare Supplemental:**

The office will bill both Medicare and secondary insurances.

⌘**Medicaid:**

Medicaid patients must provide the clinic with a ***current Medicaid card with every visit***. Medicaid patients are responsible for **all non-covered services.** Medicaid patients are responsible for applicable co-pays. Medicaid patients are responsible for securing necessary referrals from primary care physicians.

⌘**HMOs and PPOs:**

Patients are responsible for payment of the co-pay and deductible at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. If the patient is not prepared to pay the co-pay or deductible, the medical assistant or nurse will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

⌘**Commercial Insurance:**

Patients are responsible for any **co-pay, deductible, or non-covered amounts**. **Insurance is billed as a courtesy**. Patients are responsible for the **balance in full** if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, the medical assistant or nurse will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

⌘**Self-Pay:**

Patients are responsible for payment in full at the time of services for all services rendered.

⌘**Worker's Compensation:**

Patients are not responsible for any charges unless the workers compensation case has been dismissed or denied.

⌘**Personal Injury/Motor Vehicle Accidents:**

The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company will be handled by you, your insurance company, and/or your attorney.

⌘**Managed Care:**

If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient will either be required to make payment in full or pay any co-pay or deductible.

I understand the above policy and acknowledge that I am financially responsible for services rendered.

X_____ _____/_____/_____

Signature of Patient or Parent/Guardian **Date**

Authorization for Release of Information

Print Name:_____ **Date of Birth:**_____/_____/_____

PMC Physician Network is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. This release is for verbal releases only; no medical records will be mailed or faxed without written authorization.

Entity to receive information: Check each person/entity that you approve To receive information.	**Description of information to be released:** Check each that can be given to person/entity in each section.
☐ **VOICE MAIL**(provide phone number): _____	☐ Appointment Reminders (if service provided) ☐ Other:_____
☐ **SPOUSE** (provide name): _____	☐ Financial ☐ Medical as follows:_____
☐ **PARENT** (provide name): _____	☐ Financial ☐ Medical as follows:_____
☐ **OTHER** (provide name): _____	☐ Financial ☐ Medical as follows:_____

Patient Information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing*. This authorization shall be in effect until revoked by the patient.

X_____ Date: _____/_____/_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation):

_____