



Great Heights Family Medicine

REGISTRATION FORM

(please print)

Today's date:		PCP:			
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name:)	Birth date:	Age:
				/ /	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Street address:			Social Security no:		Home phone no:
					Cell Phone:
Apt #	City:		State:		Zip Code:
Occupation:	Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no:	
	/ /			()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer Address:		Employer phone no: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance		<input type="checkbox"/> Self pay	<input type="checkbox"/> BC-BS	<input type="checkbox"/> Advocate	<input type="checkbox"/>
<input type="checkbox"/> Medicare	<input type="checkbox"/> United HMO	<input type="checkbox"/> Aetna	<input type="checkbox"/> Greater Chicago	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other:
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no:		
		/ /			
Group no.:	Co-payment: \$				
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's Name:		Policy no.:		
Group no.:	Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Child	
			<input type="checkbox"/> Spouse	<input type="checkbox"/> Other:	

IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	Relationship to patient:
Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Great Heights Family Medicine or insurance company to release any information required to process my claims.	
Patient / Guardian signature:	Date:

Update: 5/14/09



REGISTRATION FORM

CONT.

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/ surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL: _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL: _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or to its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL: _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient. We do require 100% of co-pays and deductible to be paid at the time of service.

INITIAL: _____

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge \$25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

INITIAL: _____

LATE APPOINTMENTS: Patients have a 15 minute grace period to show up for their appointment. If they arrive later than that without calling, reschedule their appointment. If they do call to say they will be running late, please let them know that they have forfeited their place in the schedule and patients who show up before them will be seen first. They will then have to be worked into the schedule.

INITIAL: _____

RETURNED CHECK FEE: For any check that is returned due to non-sufficient funds, it is our policy to charge a fee of \$25.00.

INITIAL: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices (If patient did not sign, give reason and initial.)

Release of Protected Health Care Information Via Telephone To Answering Machine, or Voice Mail:

I give consent and authorization for the Medical, or Billing Staff of my Physician's office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Number () _____

INITIAL: _____

Who May We Leave Test Results With If Unable To Contact Patient or Parent?

Name _____ Relationship _____ Phone _____

Patient's Signature _____ Date _____

or

Parent/ Guardian _____ Date _____