FORM 1001-REV. 12/03

PATIENT REGISTRATION

PLEASE COMPLETE ALL WHITE AREAS

PATIENT INFORMATION

The person seeing the doctor.

TODAY'S DATE							
PATIENT NUMBER							
LAST NAME		FIRST NAME & INITIAL					
ADDRESS LINE 1							
ADDRESS LINE 2							
CITY		STATE		ZIP		E-MAIL ADDRESS	
HOME PHONE		CELL PHONE		PAGE NUMBER			
SEX		MARITAL STATUS (M/S)		DATE OF BIRTH		M.D. REQUESTING YOUR APPOINTMENT	
PATIENT'S S.S.NO.		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW ☐ PATIENT ☐ YELLOW PAGES ☐ PROVIDER BOOK ☐ OTHER					
PATIENT'S EMPLOYER							
EMPLOYER ADDRESS							
CITY		STATE		ZIP			
EMPLOYER PHONE		EXT.					

GUARANTOR

Person responsible for all unpaid balances on this account.

RESP. PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY		STATE		ZIP		E-MAIL ADDRESS	
HOME PHONE		CELL PHONE		PAGER NUMBER			
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.					
RESP. PARTY EMPLOYER		EMPLOYER PHONE		EXT.			
EMPLOYER ADDRESS		EMPLOYER FAX #					

INSURANCE

List all insurance for which you have a current card. List Medicare or Medicaid card first.

MEDICARE, MEDICAID OR INS. #1 NAME		INS. #1 CODE					
INSURANCE #1 ADDRESS		INS. #1 PHONE					
POLICYHOLDER LAST NAME		FIRST NAME / DATE OF BIRTH		RELATIONSHIP / SS #		SEX M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.			
INSURANCE #2 NAME		INS. #2 CODE					
INSURANCE #2 ADDRESS		INS. #2 PHONE					
POLICYHOLDER LAST NAME		FIRST NAME / DATE OF BIRTH		RELATIONSHIP / SS #		SEX M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.			
INSURANCE #3 NAME		INS. #3 CODE					
INSURANCE #3 ADDRESS		INS. #3 PHONE					
POLICYHOLDER LAST NAME		FIRST NAME / DATE OF BIRTH		RELATIONSHIP / SS #		SEX M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.			

Spouse, step-parent, significant other

NAME		RELATIONSHIP	
DATE OF BIRTH		S.S. NO.	
EMPLOYER		WORK PHONE	
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

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 its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL ____________

MEDIGAP AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

Name of Beneficiary (Patient) ____________ Medigap Policy Number ____________

I am giving Community Physicians of Indiana, Inc. permission to ask for Medigap Payments for my medical care.

I understand that ____________ (name of Medigap Insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to ____________ (Name of Insurer.)

I request that payment authorized by Medigap benefits be made either to me or on my behalf to Community Physicians of Indiana, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information to release to ____________ (name of Medigap Insurer) any information needed to determine benefits payable for related services.

SIGNED ____________ **DATE** ____________

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 deductibles to be paid at the time of service. **INITIAL** ____________

MISSED APPOINTMENTS:

Unless canceled at least 4 hours in advance, our policy is to charge $25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments. **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** ____________

ADVANCED DIRECTIVE

1. Do you have a living will? Yes___No___
2. Have you appointed a Health Care Representative? Yes___No___
3. Have you given anyone your Power of Attorney? Yes___No___
4. Resuscitate? Yes___No___

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.)

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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** ____________

Parent/Guardian ____________ **Date** ____________