Patient Registration Form

Account Number_____

New Patient Yes No (circle one) How did you find out about our practice?_____

_____

Patient Last Name _____First _____Middle_____

Patient Address _____

Patient Address_____City_____State____Zip _____

Home Phone_____Cell Phone_____ Sex _____Marital Status _____

Date of Birth_____Email Address_____

Social Security Number_____ Employer Name_____

Employer Address_____ Work Phone_____

Guarantor Last Name _____ First _____ Middle_____

Guarantor's Address _____

City _____State _____Zip_____Home Phone_____

Relationship to Patient _____Employer_____ Work Phone _____

Date of Birth _____Emergency Contact_____Phone Number_____

Primary Insurance _____**Policyholders Name** _____

Certificate Number _____Group Number _____ Coverage: Self Spouse Family
CIRCLE ONE PLEASE

Secondary Insurance _____**Policyholders Name** _____

Certificate Number _____Group Number _____ Coverage: Self Spouse Family
CIRCLE ONE PLEASE

I authorize Oyster Point Family Practice to release any medical information necessary to submit my insurance claims or to notify others as required. I request that my insurance companies pay benefits directly to Oyster Point Family Practice. I understand that Oyster Point Family Practice will refund me any overpayment due to me. I understand that I am financially responsible for all services received. I understand that I am responsible to pay all expenses incurred in collecting unpaid fees, including 25% collection fees on unpaid balances. It is my ultimate responsibility to collect benefits from my insurance companies. I take full responsibility for assuring that my insurance companies are properly notified in the event second opinions, pre-certifications, or pre-admission authorizations are required prior to services rendered. I acknowledge that I am responsible for a no show fee of $50.00 if I do not come for my scheduled appointment and fail to cancel 24 hours in advance.

Signed_____ Date _____

Oyster Point Family Practice Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by you or your carrier. We accept Visa and MasterCard, Discover, American Express, cash and checks.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit. We do not bill third party insurances such as car insurance for motor vehicle accidents. If you have health insurance we will bill your health insurance company. Any copays are due at time of service.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. You are responsible for paying expenses incurred in collecting unpaid fees, including 25% collection fees and any other fees related to collection of any unpaid balances.

7. If your services are to be billed to Workmen's Compensation the billing information must be provided and verified at the time of service.

8. I acknowledge that I am responsible for a no show fee of $50.00 if I fail to come to my scheduled appointment and I do not cancel 24 hours in advance.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient