Main Family Medical

Patient Registration

Patient Registration
Please Complete All Sections

Name (First, MI, Last)_____Date of Birth _____/_____/_____Age:_____ Sex: M F
Mailing Address (street) _____Apt#_____
City _____State _____Zip_____
Primary Phone (_____)_____Secondary Phone(_____)_____
SS#_____Marital Status:□ Single □ Married □ Divorced □ Widowed □ Separated
Email Address _____ Would you like to receive emails from us? Yes No
Employer _____ Phone Number (_____)_____
Employer Address_____
Other family members that are patients:_____

Parent, Spouse, or Responsible Party(statements will be addressed to responsible party)
Name (First, MI, Last)_____Date of Birth _____/_____/_____Age:_____ Sex: M F
Mailing Address (street) _____Apt#_____
City _____State _____Zip_____
Home Phone (_____)_____Daytime Phone (_____)_____SS#_____
Employer _____ Phone Number (_____)_____
Employer Address_____
Patient's relationship to Insured: □Self □Spouse □Child □Step-child □Other

Insurance Coverage-Primary
Name of Policy Holder (Insured) _____Date of Birth _____/_____/_____
Insurance Comp. Name _____Insurance Phone# (_____)_____
Policy Holder's Social Security # _____
Policy # _____ Group Number_____
Patient's relationship to Insured: □Self □Spouse □Child □Step-child □Other

Insurance Coverage-Secondary
Name of Policy Holder (Insured) _____Date of Birth _____/_____/_____
Insurance Comp. Name _____Insurance Phone# (_____)_____
Policy Holder's Social Security # _____
Policy # _____ Group Number_____

In case of emergency
Name_____Relationship to patient _____
Address _____Phone# (_____)_____

Pharmacy Information
Pharmacy Name_____
Address/Cross Streets_____Phone number# (____)_____

How did you hear about Main Family Medical?

_____

Patient Registration
Continued

Release of information and assignment of benefits:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MAIN FAMILY MEDICAL or insurance company to release any information required to process my claims.

In addition, I acknowledge that I have been informed of the MAIN FAMILY MEIDCAL's Notice of Privacy Practices. I understand MAIN FAMILY MEDICAL is a HIPAA compliant office. As a patient, I have the right to obtain a copy of the Notice of Privacy Practices at any time.

Payment Policy

Our mission at MAIN FAMILY MEDICAL is to deliver excellent and personal care that positively impacts people in a changing healthcare system. Our payment policy was created to reduce administrative costs in order to keep our fees as low as possible for our patients.

Payment is required at the time of service. Any applicable co-payments, co-insurance, negotiated payment plans and/or deductibles are due at the time of service. For patients with medical insurance benefits, we will bill your insurance. For patients without insurance, we offer a 20% discount if you pay in full at the time of service. All charges incurred at MAIN FAMILY MEDICAL ultimately the responsibility of the patient, regardless of insurance benefits.

We accept payment in the form of cash, check or credit card. A fee of $50 will be charged for returned checks.

At MAIN FAMILLY MEDICAL we want to manage our time efficiently, so we can deliver excellent personal care to our patients. We request a 24 hour notice for all cancellations/reschedules. If you no-show for your appointment you will be charged $25 on the second occurrence. This fee is not covered by insurance and is the soles responsibility of the patient. Please understand this policy is to ensure efficient time management, so all patient's get the time they need with our medical providers.

A fee will be charged for any returned checks.

I have read the Payment Policy and Release of Information described above. I understand and agree to all its provisions.

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X_____/_____/_____

PATIENT / GUARDIAN SIGNATURE DATE