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 activate your patient portal? 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

Prescription Drug Card

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

In case of emergency (Please list someone who does not live with you)

Name_____Relationship to patient _____

Address _____Phone# (_____)_____

Pharmacy Information

Pharmacy Name_____

Address/Cross Streets_____Phone number# (____)_____

How did you hear about Main Family Medical?

_____

I have read the Payment Policy and Release of Information described on page 2. I understand and agree to all its provisions.

X_____/_____/_____

PATIENT / GUARDIAN SIGNATURE DATE

Main Family Medical

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 sole 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.