Patient Registration

Main Family Medical

First Name:	Last Name:	M.I.	Date of Birth:	M ◯ F ◯
Mailing Address:			City, State, Zip:	
Cell Phone:	Secondary Phone:		Email:	
Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			
Patient's Employer:	Employer's Address:		Work Phone:	
Emergency Contact:	Relationship to Patient:		Phone Number:	

Parent, Spouse or Responsible Party

First Name:	Last Name:	M.I.	Date of Birth:	M ◯ F ◯
Mailing Address:			City, State, Zip:	
Cell Phone:	Secondary Phone:		Social Security Number:	
Employer:	Employer's Address:		Work Phone:	
Patient's relation to the insured: ◯ Self ◯ Spouse ◯ Child ◯ Step-child ◯ Other				
Preferred Pharmacy:				

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Signature of Patient or Guardian Date

PLEASE READ AND INITIAL THE FOLLOWING

CONSENT FOR TREATMENT/RELEASE OF INFORMATION: I hereby authorize MAIN FAMILY MEDICAL (MFM) to provide treatment. I authorize MFM to release information from my medical record, including information about my treatment to a third party payer or a designated review agency for the purpose of processing my claim.	Initial:
HIPPA ACKNOWLEDGEMENT: I hereby acknowledge that I have been informed of MAIN FAMILY MEDICAL's Notice of Privacy Practices and as a patient I have the right to obtain a copy of the Notice of Privacy Practices at any time.	Initial:
PAYMENT POLICY: 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 medical insurance, we offer a 20% discount if you pay in full at the time of service. All charges incurred at MAIN FAMILY MEDICAL are 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/NSF checks.	Initial:
MISSED/LATE APPOINTMENTS: At MAIN FAMILY 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 repeatedly for your appointments you will be charged a $25 fee on the second occurrence and repeated no-shows may be grounds for dismissal from the practice. This fee is not covered by insurance and is the sole responsibility of the patient. I also understand that if I am more than 10 minutes late for my appointment it may be rescheduled.	Initial:

PERMISSION TO SHARE PROTECTED HEALTH INFORMATION: MAIN FAMILY MEDICAL maintains the confidentiality of all of our patients. We respect an individual patient's right to decide who may receive information about their treatment, results, appointment times and /or anything pertinent to their health as it relates to information held on file or with the physicians/staff here at MFM. By identifying below who you are authorizing to receive protected health information about you, we will respect your wishes and only release information to them. We recognize that circumstances change; you are allowed to revise this document at any time.
I hereby allow the providers and/or staff of MFM to release appropriate protected health information on myself to the following people:

Name: Phone:	Relationship to Patient:	Initial:
Name: Phone:	Relationship to Patient:	Initial:

ASSIGNMENT OF BENEFITS (NON- MEDICARE); I hereby authorize payment directly to MAIN FAMILY MEDICAL of all healthcare benefits and understand that I am financially responsible for all charges whether or not they are paid by insurance .	Initial:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND VOLUNTARILY AGREE TO ITS PROVISIONS.

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PRINTED PATIENT'S NAME DATE

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SIGNATURE OF PATIENT(or Parent or Guardian if patient under 18) RELATIONSHIP TO PATIENT