PATIENT REGISTRATION AND BILLING INFORMATION FORM

PATIENT
LAST NAME _____ FIRST NAME_____ MIDDLE INITIAL _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE#_____CELL PHONE#_____

D.O.B_____S.S. # _____ SEX (M/F) ____MARITAL STATUS_____

RACE: ASIAN [ ] BLACK/AFRICAN AMERICAN [ ] WHITE [ ]
NATIVE HAWAIIAN [ ] ALASKA NATIVE [ ] MORE THAN ONE [ ]

ETHNICITY HISPANIC OR LATINO [ ] NOT HISPANIC OR LATINO [ ] LANGUAGE_____

REFERRED BY _____ PHARMACY_____

PRIMARY CARE DOCTOR NAME, ADDRESS & PHONE#_____

SECONDARY CONTACT NAME, RELATIONSHIP, PHONE #_____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE#_____ EXT _____

ADDRESS_____ CITY_____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than patient) _____

ADDRESS_____ CITY_____ STATE____ ZIP _____

RELATIONSHIP _____ D.O.B._____PHONE NUMBER _____

I authorize the release of any medical information necessary to process this claim. Signature_____Date _____	I authorize payment of medical benefits to my physician or supplier for services provided. Signature_____ Date _____

PAYMENT POLICY FOR SERVICES RENDERED

1. IF YOU HAVE COVERAGE WITH AN INSURANCE COMPANY WHICH WE DO NOT HAVE A CONTRACT WITH, we will submit a claim directly to your insurance company for reimbursement. Please review the following procedure and initial.
"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office immediately. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility." INITIAL _____

2. IF YOU DO NOT HAVE INSURANCE, you are responsible for payment of your bill, in total, at the time of your visit. We accept Credit cards, and cash. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit.

3. "I understand and agree that regardless of my insurance, I am in the end responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and San Fernando Internal Medicine incurs collection charges, they will be my responsibility."

_____ _____
Patient or Guardian Signature Date