

**PATIENT INFORMATION**

**Patient Registration Information**

Name: \_\_\_\_\_  
First MI Last

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt City State Zip

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Physician: \_\_\_\_\_  
Name of Physician/Individual Name of Physician/Individual

Are you employed? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Full-Time \_\_\_\_Part-Time \_\_\_\_Self-Employed \_\_\_\_Retired

Are you a student? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Full-Time \_\_\_\_Part-Time

Marital Status \_\_\_\_Single \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Widowed

Is the patient \_\_\_\_A minor child\* \_\_\_\_an adult dependent\*

\* If you checked either, please see the receptionist for additional information.

**Primary Insurance Information**

Please present your card at each visit. Deductible amount: \_\_\_\_\_ Co-pay amount: \_\_\_\_\_ PCP: \_\_\_\_\_

Insurance Company Name Claims Mailing Address City State Zip

Telephone Contact Person Group # Policy #

Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer: \_\_\_\_\_

**Secondary Insurance Information**

Please present your card at each visit. Deductible amount: \_\_\_\_\_ Co-pay amount: \_\_\_\_\_ PCP: \_\_\_\_\_

Insurance Company Name Claims Mailing Address City State Zip

Telephone Contact Person Group # Policy #

Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer: \_\_\_\_\_

**Accident Information**

Is this illness/injury the result of an accident? \_\_\_\_Yes \_\_\_\_No

Where did it occur? \_\_\_\_Work \_\_\_\_Auto \_\_\_\_Other Date of accident: \_\_\_\_\_

Have you reported the illness/injury to your employer? \_\_\_\_Yes \_\_\_\_No

**Notice: This office does not treat worker's compensation illness/injuries or file worker's compensation claims.**

Patient Initials: \_\_\_\_\_

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**Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative**

**\*\*Please read and initial each paragraph\*\***

\_\_\_\_\_ **Medicine Associates of North Texas** and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

\_\_\_\_\_ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Medicine Associates of North Texas** for any services furnished to be by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_ I appoint **Medicine Associates of North Texas** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

\_\_\_\_\_ Unless I request to the contrary in writing, I will accept appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of this practice.

**Patient Financial Responsibility Statement**

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through \_\_\_\_\_  
(Insurance Company)

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  - 1) This is a pre-existing illness that is not covered by your plan
  - 2) You have not met your full calendar year deductible
  - 3) The type of medical service required is not covered by your plan
  - 4) The health plan was not in effect at the time of service
  - 5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,  
**Medicine Associates of North Texas**

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date