

## PATIENT REGISTRATION FORM

Today's Date:		Drivers license #:		Age:	Date of Birth:
Patient Name: <small>( Last) ( First) ( Middle)</small>			Social Security #:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Billing Address: <small>Street / P.O. City State Zip</small>					
Home Phone		Cell Phone:		Work Phone	
Email Address:				Ht:	Wt:
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other			Ethnicity: <input type="checkbox"/> American <input type="checkbox"/> Hispanic <input type="checkbox"/> Canadian <input type="checkbox"/> Polish <input type="checkbox"/> Irish <input type="checkbox"/> Italian <input type="checkbox"/> German <input type="checkbox"/> Other		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Italian <input type="checkbox"/> German <input type="checkbox"/> Other:					
Facility where you reside (if applicable):			Facility Phone:		
Insured's Employer:		Contact Person:		Office Phone:	
Employer Address:				Fax Phone:	

### Guarantor/ Legal Guardian Information

Emergency Contact Name:		Relationship		Primary Phone:	
Address:				Secondary Phone:	
Power of Attorney Name:				Phone:	

### Pharmacy Information

Pharmacy Name:		Pharmacy Phone #:	
Pharmacy Address:			

### Insurance Information

Primary Insurance	Secondary Insurance
Co. Name: _____	Co. Name: _____
Address: _____	Address: _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone No: _____ Fax No: _____	Phone No: _____ Fax No: _____
Member ID#: _____ Group #: _____	Member ID#: _____ Group #: _____
Insured Name: _____	Insured Name: _____
Relationship: _____	Relationship: _____
SSN#: _____ DOB: _____	SSN#: _____ DOB: _____
INSURANCE COPAY: _____ DEDUCTIBLE: _____	INSURANCE COPAY: _____ DEDUCTIBLE: _____

# FINANCIAL POLICY

Patient Name (print name):

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a large number of health plans, thereby making our services accessible to as many patients as possible. Please understand that in order to continue to provide outstanding services to our patients we need to maintain our administrative cost to a minimum.

Hereto is a summary of our financial and billing policies to identify clearly our processes, whereby your signature below acknowledges understanding of our financial policies outlined below:

- 1) FILED CLAIMS: the office will file all claims for services rendered to primary and secondary insurances. **It is the patient's responsibility to furnish accurate, complete and current insurance information.**
- 2) PAYMENTS: we file secondary insurance claims for all our patients. However, in many cases secondary insurances will pay patients directly or your insurance policy has deductibles, coinsurances or similar provisions that will result in a non-payment for balances after your primary insurance has paid a claim. **We reserve the right to bill any unpaid balances directly to the patient if no payment from a secondary insurance is received within 60 days after filing.** These balances are due in full from the patient at the time of statement receipt.
- 3) BILLING: questions regarding the billing process, charges on your account or to update or change information have to be addressed to the office in **care of Billing Department.** **Inquiries via phone should be directed to the Billing Department at 352-549-9962** (located in top right corner of your statement) rather than office, to avoid delays in processing.
- 4) CREDITS: In cases where patients pay an open balance and payment from a secondary insurance is received for the same claim, the office will refund any credits resulting from such payment to the patient provided the total credit balance is equal or greater than \$20.00. Credit balances less than \$20.00 will remain on the account and will be used towards future balances or refunded once the total credit amounts reach \$20.00.
- 5) INSURANCE CO-PAYS: Because of the variety of different plans and contracts insurances have and the constant changes within each plan, we cannot be held responsible for the accuracy of co-payments collected. **In rare cases we have discrepancies between collected amounts and the amounts your insurance contract requires.** Adjustments of this nature will be made at the time the insurance notification is received and either credited to patient's account or billed to the patient.
- 6) COLLECTIONS: We try to work with patients to find ways to make the payment process as easy as possible. **However, if we do not receive payment after the stated grace period, accounts may be evaluated for further collection process and the office may consider discharging a patient from the practice for non-payment(s).**

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

## PATIENT ACKNOWLEDGEMENT

*By my signature below, I acknowledge to have read the above polices and agree to the terms and outlines. I understand my responsibilities and the consequences for violation of the financial responsibilities. I was given opportunity to ask questions regarding the financial policies and understand their impact on my relationship to the Infusion Center..*

Patient Signature:

Date: