PATIENT REGISTRATION

PATIENT INFORMATION

Name_____
Last First M.I.

Address_____
City State Zip

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Preferred contact number (check one): ( ) home ( ) cell ( ) work

Other person(s) who may receive your medical information (e.g. biopsy reports, etc):
_____

Date of Birth ___/___/___ Age___ Gender___ Social Security #_____

Marital Status____ Emergency contact_____

Other family members that are patients:_____

Referred by:_____ Primary Care Physician_____

Pharmacy name/phone number:_____

Parent/Guardian (if child):_____ Relationship_____

PRIVACY RELEASE

I authorize the release of medical information to my primary care or referring physician, to consultants and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

PLEASE CHECK ONE: I ___request ____defer a full copy of the privacy notice.

FINANCIAL POLICY AND CANCELLATION POLICY

Payment is due at time of service unless you have a health insurance plan in which we participate; for those patients, copays and deductibles will be collected. You will be responsible for any balance not covered by the insurance. You are also responsible for knowing your deductible and whether or not it has been met. We accept payment in the form of cash, check, and credit card. Patients without insurance must pay by cash or credit card. Returned check fees are $25. If your account is transferred to collections you will be charged a collection fee. We require 24 hours notice for cancellations or you will be charged $25. A $50 fee is charged for cancelled surgeries. We reserve the right to discharge patients for frequent no-shows and last minute cancellations. Your signature below signifies your understanding with this policy.

Patient or Guardian_____ **Date**_____