

**UNIVERSITY HOSPITALS MEDICAL PRACTICES**  
**Patient Registration Form – Adult & Specialty**

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**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

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

**Mailing** Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (H) \_\_\_\_\_

Phone (W) \_\_\_\_\_ Phone (C) \_\_\_\_\_ **Soc Sec Num** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex: M F Marital: S M D W Student: Y N **Patient's Date of Birth** \_\_\_\_\_ (important)

**RESPONSIBLE PARTY/GUARANTOR**

**Note: The responsible party/guarantor will get the bill and is responsible for payment – patients 18 or older will automatically be setup as their own Guarantor unless authorized by signature below)**

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

**Mailing** Address (If different from patient) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Sex M or F **Soc Sec Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_

Relationship to Patient (circle): Self Spouse Father Mother Guardian Other \_\_\_\_\_

<p><b>I authorize the above Guarantor to receive my medical bills:</b> _____ <span style="float: right;"><b>Signature</b></span></p>
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**INSURANCE & POLICY - HOLDER INFORMATION**

**Primary** Insurance Company Name \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Policy Holder** Name \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Relationship to Patient (circle): Self Spouse Father Mother Guardian Other \_\_\_\_\_

**Secondary** Insurance Company Name \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Policy Holder** Name \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Relationship to Patient (circle): Self Spouse Father Mother Guardian Other \_\_\_\_\_

**PHYSICIAN INFORMATION**

**Primary** Doctor's Name \_\_\_\_\_

List all doctors this patient has seen in the last 3 years – please estimate the month / year last seen

<b>Doctor</b>	<b>Month/Year</b>	<b>Doctor</b>	<b>Month/Year</b>
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____

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**ASSIGNMENT & RELEASE – TREATMENT & RECORDS**

- I agree to permit authorized personnel of **University Primary & Specialty Care Practices** to perform routine medical treatment, examinations, laboratory tests, and emergency procedures as deemed necessary by the doctors in this office.
- I hereby assign my insurance benefits to be paid directly to the attending physician. I also authorize the attending physician and his/her designee to release information acquired in the course of my examination and treatment necessary to process claims and/or provide care.
- I acknowledge receiving a copy of the “**Notice of Privacy Practices**”:      **YES**      **NO**      If NO, explain reason below:

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**I agree that this authorization is valid regardless of when I receive services at this office and that I am the patient or authorized to sign this document.**

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*Patient or Authorized Party Signature*

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*Date*

**FINANCIAL AND MANAGED CARE POLICY STATEMENT**

University Primary Care Practices adheres to the policies below. The patient / responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

- Patients with an insurance co-payment are expected to make payment when checking in for the appointment.
- Patients with **high deductible** (\$1000 or more) plans are required to pay the following fees prior to their doctor visit: \$125.00 for first new patient visit, \$75.00 for each subsequent visit, \$150.00 for consultations. Patients will be refunded or billed for additional amounts as appropriate after claim(s) are processed by their insurance company.
- Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
- Not all services are covered benefits of all insurance plans. The patient / responsible party maintains the responsibility of verification of applicable coverage.
- The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.
- Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). Returned checks and balances older than 45 days may be subject to additional collection fees.

We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today’s appointment. Thank you for your understanding and cooperation with this policy.

**I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.**

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*Patient/Responsible Party Signature*

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*Date*

**Patient name if different from Responsible Party:** \_\_\_\_\_