

DATE: _____
LCFP Rep Initials: _____

PCP: _____
CHART #: _____

PATIENT REGISTRATION FORM
(Please Print)

Patient Name: Last First Middle M / F ()
Home Phone
Street Address City State Zip Code
Mo. Date / / Year of Birth Marital Status Referred By Social Security Number - -
Employer's Name Employer's Address: Street Address, City, State, Zip
()
Work Phone Number Your Occupation Your Insurance Company
Policy/Member # Group Number

Responsible Party Name: Last First Middle ()
Or Spouse Home Phone
Street Address City State Zip Code
Mo. Date / / Year of Birth Social Security Number Relationship to Patient - -
Employer's Name Employers Address: Street Address, City, State, Zip Work Phone ()
Insurance Company Subscriber's Number (SS#) Policy Number

CHILDREN/FAMILY

<u>Name</u>	<u>Date of Birth</u>	<u>Name</u>	<u>Date of Birth</u>
1) _____	____ / ____ / ____	4) _____	____ / ____ / ____
2) _____	____ / ____ / ____	5) _____	____ / ____ / ____
3) _____	____ / ____ / ____	6) _____	____ / ____ / ____

IN CASE OF EMERGENCY:

Nearest Relative or Friend NOT Living with you Relationship to Patient () Home Phone () Work Phone



PATIENT AUTHORIZATION

I authorize the providers to submit any and all health care information to any health insurance program for their review and payment. Payment [] should or [] should not be directed to the practice.

Signature

_____/_____/_____
Date

I further understand and agree to pay for services or amounts due to the physician even when the physician accepts assignment. The charges could include amount applied to my annual deductible, co-payment amounts, and charges denied as not covered by my insurance program or considered medically unnecessary. Examples of these denied charges may include injections, routine medical care not due to an illness or condition, and any other services specified in my health insurance contract.

Signature

_____/_____/_____
Date

I request that payment of authorized Medicare benefits be made on my behalf to Lake County Family Practice, Inc., for any service furnished me by any of these physicians. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If the appropriate item of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the remaining amount between Medicare's payment and the Medicare allowed charge, any deductibles, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

_____/_____/_____
Date