PATIENT REGISTRATION

First Middle Last MM/ DD/ YYYY

Full Name _____ DOB _____

Address _____

Phone: Home _____ Cell _____ Work _____

Email _____ Contact Preference: ☐Home ☐Cell ☐Email

☐Male ☐Female ☐Single ☐Married ☐Widow ☐Divorced SS# _____

Race _____ Ethnicity _____ Language Preference _____

Emergency contact _____ Relation _____ Phone _____

Pharmacy Name/Address _____

Employer Name/Address _____

Referred by _____

Primary Insurance _____ Subscriber's Name _____

Subscriber's: DOB _____ SS# _____ Relation to Patient _____

Secondary Insurance _____ Subscriber's Name _____

Subscriber's: DOB _____ SS# _____ Relation to Patient _____

INSURANCE/MEDICARE AUTHORIZATION : I hereby authorize Parag B. Thakkar MD SC or its agent to release any information necessary to evaluate or administer claims of benefits to my insurance company/Medicare or its agents. I also authorize that payment for such benefits be made directly to Parag B. Thakkar MD SC or its agent. I understand that I am financially responsible for any amount not covered by my insurance company.

TELEPHONE MESSAGE AUTHORIZATION: I authorize Dr. Parag B. Thakkar or his agent to leave a message about my appointment, laboratory studies or other medical information on my answering machine/ voice mail or with my spouse or significant other who may answer my phone. **(We will not leave specifically protected health information such as HIV, mental health etc..)**

RECEIPT OF NOTICE OF PRIVACY POLICY: I have received a copy of notice of privacy practices.

Signature _____ Date _____

Patient/Guardian

PATIENT REGISTRATION

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. You may also be required to make additional payment at the time of the visit to cover the deductible. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will make reasonable attempt to let you know if any service is likely to be not covered but ultimately it is your responsibility to check with your insurance about coverage. You are responsible for full payment of the non-covered services.

4. **Proof of insurance.** All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in reasonable period, the balance will be billed to you.

7. **Nonpayment. I**f your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and a certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** Please cancel your appointment 24 hours in advance. Our policy is to charge $25 for missed (no show) appointment or late cancellation. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature _____ Date _____

Signature of patient or responsible party

Full Name _____