PATIENT REGISTRATION

(PLEASE PRINT)

Referred to this office by:_____ Primary Care Physician:_____

Patient's Name:_____ Age:_____
FIRST MIDDLE LAST

Date of birth:_____ Sex: ☐ Male ☐ Female Social Security #:_____

Address:_____
Street City/State Zip

Mailing Address: _____
Street City/State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext:_____

Employer: _____ Preferred language: _____Race: _____Ethnicity: _____

Preferred Method of Contact: Phone ☐ Email ☐ Letter ☐ Email address:_____Pharmacy:_____

SPOUSE'S INFORMATION

Spouse's Name:_____ SSN#: _____ Date of Birth: _____

Spouse's Employer:_____ Work Phone:_____

MINOR

(Under 18 years of age)

Father/Mother:_____ Social Security #: _____

Employer:_____ Position:_____ Work Phone:_____

INSURANCE INFORMATION

**** PRIMARY INSURANCY COMPANY: ****

Insurance Company:_____Member ID #:_____

Address:_____ Group/Policy Number: _____

Subscriber's Name:_____Subscriber's Employer:_____

Relationship to Patient:_____Subscriber's Date of Birth: _____

Subscriber's Phone Number:_____Subscriber's SSN: _____

**** SECONDARY INSURANCY COMPANY: ****

Insurance Company:_____Member ID #: _____

Address:_____Group/Policy Number: _____

Subscriber's Name:_____Subscriber's Employer:_____

Relationship to Patient:_____Subscriber's Date of Birth: _____

Subscriber's Phone Number:_____Subscriber's SSN: _____

TURN OVER

LABOR & INDUSTRIES CLAIMS

On the Job Injury: Yes☐ No☐ Claim #:_____ Date of injury:_____

Location of injury: Home☐ School ☐ Work☐ Auto Accident☐Other_____ Time: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED

(Not living at same address)?

Name:_____Relationship to Patient:_____Phone:_____

Do you have the following:	Advanced Directive	Yes___ No___	Executing an Advanced Directive will not alter the type or manner of medical care given to patients.
	Living Will	Yes___ No___	
	Durable Power of Attorney	Yes___ No___	

FINANCIAL AGREEMENT

I plan to make payment for medical expenses with:☐Insurance ☐Cash/Check/Credit Card ☐Payment Agreement

The total balance for services rendered to the above patient are due and payable 60 days from the date of service. A $10.00 per month rebilling fee will be assessed on outstanding accounts.

Cancellation Policy: We require notification 24 hours in advanced of missed appointments, surgeries, or procedures, so that we may schedule other patients in need of medical care. Failure to comply with this policy will result in a $25.00 or $100.00 fee respectively. _____

Initials

INSURANCE AUTHORIZATION/ASSIGNMENT AND RELEASE

In consideration of the services rendered to the patient listed above, I hereby agree to pay Sheila C. Lally, DO in accordance with the physician's regular rates and terms. I understand that as a courtesy, her office will submit these charges to my insurance company.

I authorize my Insurance benefits be paid directly to the physician. I understand that I am personally responsible for any and all medical charges not covered by my insurance company, regardless of my insurance coverage. I authorize the doctor and/or insurance company to release any information required for this claim. I authorize the doctor to release all necessary information to the hospital/surgical center and medical equipment suppliers if surgery is indicated. I also authorize the doctor to release medical information regarding my care to my referring doctor and/or my primary care physician.

I understand that Sheila C. Lally, DO shall have the right, at any time, to refuse to provide medical care or treatment for the patient listed above.

Our billing office is available to assist you with any questions you may have regarding the above information.

Signed:_____ **Date:**_____

Revised: 10/11