

MedNow Clinic Ellsworth

Welcome To Our Office

Registration form for 2009

Please Print Clearly

Patient Name: _____

First

Middle

Last

Complete Mailing Address: _____

_____(_____)_____

City

State

Zip Code

Home Phone #

Work Phone #

(_____)_____/_____/_____ circle one ____/____/_____

Cell Phone #

Date of Birth

Male or Female

Social Security #

Employer's Name: _____ Occupation: _____

Employer's Address: _____

City

State

Zip Code

School Name: _____ None Part-time Full-time

Marital Status: M S D W Spouse's Name: _____ Work Phone #: (____)_____

Next of Kin Contact Information: _____

Person to notify in case of emergency: _____ Relationship: _____

Mailing Address: _____

Street or PO Box

City

State

Zip Code

Telephone #_(____)_____ Work #_(____)_____

Person Responsible for Payment, if not Patient: _____

Mailing Address: _____

Street or PO Box

City

State

Zip Code

Phone #_(____)_____ Work #:_(____)_____ Cell #:_(____)_____

Race (Optional) _____ E-Mail Address (Optional) _____

Insurance Information

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance: _____ ID# _____ Group # _____

Subscriber of Insurance: _____ Relationship: _____

DOB: ___/___/___ SSN: ___-___-___ Male/Female Phone# (___)_____ Work # (___)_____

PLEASE PRESENT YOUR INSURANCE CARDS AND YOUR DRIVERS LICENCE OR OTHER FORM OF ID TO THE RECEPTIONIST

Medicare Part B

All claims will be submitted to Medicare for me. I understand that Medicare will consider claims providing there is a medical diagnosis. **Medicare does not pay for preventative health services such a Tetanus Injection, Routine Physical Exams, GYN Physicals, Routine Hearing Tests, Benign Skin Lesions for cosmetic reasons, or any tests that they do not deem "medically necessary"**. If, despite knowing this, I agree to have tests that are not covered by Medicare performed, I agree to be personally and fully responsible for payment.

Patient's Signature

Date

ALL PATIENTS PLEASE READ OUR PAYMENT POLICY CAREFULLY AND SIGN AT THE BOTTOM. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE RECEPTIONIST.

I assign any and all medical and/or surgical benefits from my insurance company to MedNow Clinic Ellsworth. I understand that I am responsible for any and all charges incurred whether my insurance company covers them or not. I am responsible for my co pay, deductible, coinsurance, or any other balance or non-covered service as per my insurance policy. I understand that payment is due today, but if I am billed for any balance or charge after my insurance company or as per a prior agreement made with the billing office, payment is due immediately. If I fail to follow these guidelines, I may be charged a collection fee and my information will be sent to the our Collection agency. I may be discharged from this practice, whether I come back for a personal issue or a liability issue. I authorize the release of any medical or other information necessary to my insurance company to process this claim. If I need to be referred outside of MedNow Clinic, I authorize the release of my records to the place of referral.

Signature

Date