Care Medical Group Patient Registration

Patient Personal Information

Patient's Legal Name: _____
First M.I. Last

Mailing Address: _____
Street Apt. #

_____
City State Zip

Phone #: _____Cell/Home/Work Secondary #: _____ Cell/Home/Work

Date of Birth: _____ Social Security #: _____

Birth Sex (assigned sex at birth): M _____ F_____ Other: _____ Gender Identity: _____

Email address: _____ Employer: _____

Do you have any food/drug allergies or reactions: _____

Emergency Contact Name: _____ Relation to patient: _____

Phone #: _____ Cell / Home / Work

I authorize the person named below to discuss treatment and/or medications on my behalf (OPTIONAL):

Name: _____ Relation to patient: _____

Insurance Information

*Do you have medical health insurance?: Y_____ N_____

*If yes, is your primary or secondary insurance coverage Medicare/Medicaid?: Y_____ N _____

Primary Insurance Name: _____ ID #: _____

Policyholder's Name: _____ Relation to Patient:_____

Policyholder's Date of Birth (if not self): _____ Phone #: _____

Policyholder's Address (if not self): _____

Initial below:

I acknowledge receiving the Notice of Privacy Practices for Care Medical Group _____
I understand and have been provided a copy of Care Medical Group's Self-Pay Policy _____
I understand and have been provided a copy of Care Medical Group's No-Show/Late Cancellation Policy _____
I understand and have been provided a copy of Care Medical Group's Patient Financial Responsibility Agreement _____
I request that payment of authorized INSURANCE COMPANY benefits be made on my behalf to Care Medical Group. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and/or any other INSURANCE COMPANY any information needed to determine these benefits or the benefits payable for related services. It is patient responsibility to know their insurance benefits/coverage for all services rendered. We make every attempt to determine coverage prior to visit(s). Confirmed eligibility of benefits is not a guarantee of insurance payment. I have carefully read these payment and credit policies. I accept full responsibility, on the terms and conditions stated herein, for payment of services rendered and charges incurred, should this be required. I will bear the cost of collection and/or court fees and attorney fees should this be required.
PLEASE NOTE: If you are being seen for Occupational Medicine services, these services will be billed directly to your employer. According to the Care Medical Group/Employer contract, the financial responsibility falls upon the employer and not the patient.

***Signature:** _____ ***Date:** _____