Registration Form

PCP:____________

Patient____
(Use Legal Name) Last First M.I. Preferred Name

Address____
Street

_____________________ _____________ _____________
City State Zip Code

SSN_______________________ Birthdate________/________/________ Sex: M_____ F_____

Employer_____________________ Phone Home____________ Work___________ Cell___________

Married_______ Single________ Divorced_______ Widowed_______

Responsible Party (if other than Patient)

Name____
Last First M.I.

Address____
Street

_____________________ _____________ _____________
City State Zip Code

SSN_______________________ Birthdate________/________/________ Sex: M_____ F_____

Employer_____________________ Phone Home____________ Work___________ Cell___________

Relationship to patient: ____________________________________

INSURANCE

Primary ____________________________ID # _____________________Group #__________

Subscriber__________________________ SSN#_________________ Birthdate _____/______/______
Last First M.I.

Secondary ____________________________ID # _____________________Group #__________

Subscriber__________________________ SSN#_________________ Birthdate _____/______/______
Last First M.I.

Emergency Contact ____

Home____________ Work___________ Cell___________ Relationship to patient: ________________

Pharmacy: _______________________ **Location:**_______________________________________

Treatment Authorization

The undersigned, as patient (or as parent or guardian of the patient), do hereby authorize the attending physician/practitioner to medically and/or surgically manage the treatment of the above named patient and to provide such surgical and/or medical treatment, which, in the physician/practitioners judgment, is deemed necessary for the benefit of the patient.

Signature____ **Date**_______________

McKenzie Family Practice, P.C.
Financial Agreement

As a courtesy to our patients we bill your insurance company for you. If our office has not received payment or a denial within 45 days of the date of service the charges will be made patient responsibility. It will be your responsibility to contact your insurance company in regards to payment. Please initial______________________

The following paragraphs detail you're your financial responsibility with McKenzie Family Practice, P.C.:

1. **Financial Agreement**: I, the undersigned, agree, whether I sign as agent or as patient, that in consideration of the medical services rendered to the patient, I hereby individually obligate myself to pay the account to McKenzie Family Practice, P.C. Payment at the time of service is required on all new accounts unless alternative arrangements have been made with the Business Manager.

2. **Assignment of Insurance Benefits:** I, the undersigned, hereby authorize payment directly to McKenzie Family Practice, P.C., of the group or personal benefits or any other insurance benefits otherwise payable to me, for medical services rendered by the clinic.

3. **Patient Certification, Authorization to release Medical Information:** I, the undersigned, authorize McKenzie Family Practice, P.C. to release any medical information that may be necessary to request claim reimbursement from insurance companies to whom claims have been submitted, and to release credit information to appropriate information gathering agencies.

4. **Collection Fees:** I, the undersigned, agree that if payment on this account is not made in accordance with the above mentioned terms, I will pay reasonable attorney's fees and other costs incurred for collection.

I certify that I have read the foregoing, and I am the patient, or am duly authorized to execute the above agreement and accept its terms.

Responsible Party____

Relationship to Patient____

Date_____________________________