Family Medicine Registration Form

Please print and use black ink.

Preferred location: ____Phenix City ____Opelika Hwy 280 ____Fort Mitchell ____Opelika Executive Park

Patient's Information

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Last Name: _____ First Name: _____ Middle Initial: _____

Address Line 1: _____ Date of Birth: _____ Gender: M or F

Address Line 2: _____ Home Phone: (_____) _____

City: _____ Work Phone: (_____) _____

State: _____ Zip Code: _____ Cell Phone: (_____) _____

Race: _____ Ethnicity: _____ Social Security #: _____

Preferred Pharmacy: _____ Driver License State ____# _____

Occupation/Employer: _____ Email Address: _____

Previous Doctor: _____ Reason for Leaving: _____

Complete list of ALL medications taken in past year:

_____

_____

_____

Emergency Contact Information (A local person)

Last Name: _____ First Name: _____

Relationship: _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Cell Phone: (_____) _____

HIPPA Disclosure (People other than yourself)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: (_____) _____ Phone: (_____) _____

Subscriber Information Please provide all applicable insurances. Not providing all the insurance information will result in a delay in making your first appointment.

Last Name: _____ First Name: _____ Middle Initial: _____

Address Line 1: _____ Date of Birth: _____ Gender: M or F

Address Line 2: _____ Home Phone: (_____) _____

City: _____ Work Phone: (_____) _____

State: _____ Zip Code: _____ Cell Phone: (_____) _____

Social Security #: _____ Email Address: _____

Primary Insurance Company: _____ Subscriber ID Number: _____

Group Number on Insurance Card: _____ Phone # on Back of Card: _____

Secondary Insurance Company: _____ Subscriber ID Number: _____

Group Number on Insurance Card _____ Phone # on Back of Card: _____

How did you hear about us? Check One

Friend	TV	Advertisement	Google/Internet	Yellow Pages

Newspaper Ad	PR Manager	Facebook	OBGYN	Other: please explain

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

Consent is hereby given to perform any and all examinations, tests, procedures, and treatments necessary and/or advisable; and in an emergency, without the presence of parents or responsible adults. I hereby authorize examination and treatment of the above-named patient by the physicians and physician extenders employed by Preferred Medical Group. I realize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this practice.

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Preferred Medical Group will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your insurance company fails to fully compensate Pinnacle Enterprises PC within this time frame, any unpaid balance becomes your sole responsibility.

CONSENT TO OFFICE POLICIES AND PROCEDURES

- I understand that Preferred Medical Group has a smoke free office for the health and wellbeing of all patients, parents and staff, and agree to come to the office without the smell of cigarette smoke on my clothing or personal possessions.
- I understand that Preferred Medical Group does not allow eating or drinking in its offices in order to maintain sanitary facilities for all patients and staff.

- I understand that Preferred Medical Group requires 24-hours advance notice for an appointment to be rescheduled. A cancellation with less than 24-hours' notice results in a "No Show." I acknowledge that Preferred Medical Group reserves the right to discharge a patient after 3 missed appointments. I also understand that for each "No Show" I may accumulate a $25 No Show Fee, which I must pay to be seen again. Failure to pay this fee may result in discharge.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

- I authorize Preferred Medical Group to file insurance claims for services and supplies rendered to and for the patient.
- I authorize Preferred Medical Group to release information, including my medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the Internet.
- I authorize that payment of all third-party benefits otherwise payable to me be made directly to Preferred Medical Group.
- I assign to Preferred Medical Group all payments for medical services and supplies.

I understand that I am financially responsible to Preferred Medical Group for the above-named patient(s). If my insurance company fails to fully compensate Preferred Medical Group, any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third-party payer within 30 days after notification from Preferred Medical Group and/or a billing company acting on its behalf. I agree to pay all costs of collection, including attorney's fees and agrees to pay the legal rate of interest on the account until paid in full.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES AND GUARANTEE OF PAYMENT

I understand that Preferred Medical Group cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

****** Please initial:*** **_____** *I/WE ACKNOWLEDGE THAT I/WE HAVE RECEIVED OR REVIEWED A COPY OF THE FOLLOWING, ALL OF WHICH ARE FOUND AT www.preferredmedicalgroup.com: 1) POLICIES ON HIPAA, 2) POLICIES AND PROCEDURES, and 3) HEALTH FORM POLICIES.*

_____

Patient Signature Date

_____

Witness Signature Date

Accepted By: _____ Date: _____