Patel & Patel, M.D. Inc.

New Patient Registration Form

Name:_____ DOB:_____Age:_____Sex: ( ) M / ( ) F

Address:_____ Phone:_____

City, State, Zip:_____ Marital Status: Married ( ) Single ( ) Other ( )

In Case of Emergency, Notify:_____ Phone:_____

Relationship to Patient:_____

Referred by:_____

How did you hear about our practice?_____

Pharmacy Name:_____ Phone:_____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

ID Number:_____ ID Number:_____

Name/Policy Holder:_____ Name/Policy Holder:_____

SSN:_____DOB:_____ SSN:_____DOB:_____

Responsible Party Information

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility.

X_____Date:_____

Responsible Party Signature

Payment of Benefits: I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature:_____ Date:_____

Medical Release Authorization: I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to provide false information or leave out facts I know are important.

Signature:_____ Date:_____

FINANCIAL AND OFFICE POLICIES

Thank you for choosing Patel & Patel, M.D., Inc. as your healthcare provider. Our entire staff is committed to providing our patients with the highest quality of care. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions you may have regarding our fees, financial policy, or your responsibility.

PAYMENT METHODS

We accept all major credit cards, checks, money orders and cash.

REGISTRATION & INSURANCE REQUIREMENTS

We require complete, accurate and up-to-date information on your registration form in order to bill your insurance company. New and Established patients must supply a current copy of their insurance card at each visit. This allows us to assist you in collecting the benefits from your insurance company to which you are entitled. We will ask you to update your registration form annually, and ask that you update us when changes occur (address, insurance coverage, phone number, name, etc.).

MEDICAL INSURANCE

Medical Insurance is a contract between you and your insurance company. Our office is not a party to that contract. Not all services may be considered covered by your insurance company. We encourage you to become familiar with your insurance plan and benefits to verify coverage for recommended services, tests, ultrasounds, laboratory studies and referrals to other doctors. This office will not be responsible for out-of-pocket expenses incurred from utilizing an out-of-network provider, facility, or for undergoing non-covered tests or procedures.

CO-PAYS

All co-pays are collected at the time of service.

SELF-PAY PATIENTS

If you do not have insurance you will be asked to prepay $200.00 toward your initial visit. Likewise, any associated surgery or ultrasounds will require a minimum prepayment and the balance will be billed to you monthly. We will accept monthly payments but payments must be received at least every 30 days to keep the account active and avoid collections. All balances must be paid in full within 180 from the date of service.

SURGERY & PRE-AUTHORIZATIONS

We will contact your insurance company to obtain a pre-authorization prior to your surgery. Obtaining a pre-authorization does not mean your surgery will be covered at 100% and insurances do not guarantee any payments or benefits until after the surgery is completed and a claim has been submitted. After we contact your insurance company we will reach out to you to explain your benefits, deductibles and co-pays prior to surgery.

FINANCIAL & OFFICE POLICIES CONT.

OB BILLING & PAYMENTS

Our staff will be happy to meet with you following your initial new OB visit to discuss fees associated with your pregnancy, if needed. The global fee for obstetric care includes your routine prenatal office visits, uncomplicated delivery, and postpartum visit. This global charge will be billed to your insurance shortly after delivery. Tests including pap smears, blood work, ultrasounds, NSTs, and injections provided during your pregnancy and at your postpartum visits are not included in the fees mentioned above. Hospital visits outside of your delivery stay are also billed separately. These charges are billed to your insurance at the time they are performed. Payment is due on your account for these charges throughout your pregnancy. You are responsible for any charges not covered by your insurance.

MISSED APPOINTMENTS

We appreciate your help and the courtesy of a call if you going to be more than 10 minutes late for your appointment. Please notify our office at least 24 hours in advance of any cancellation.

DISABILITY, FMLA & OTHER FORMS

We realize that special forms are sometimes necessary to provide documentation of medical conditions. We are happy to complete these forms. All forms will be completed after a payment of $25.00 is collected. Please allow 7 days for completion of forms.

MEDICAL RECORDS

Medical Records can only be released upon the patient's completion of an "Authorization to Release Medical Records" form. Only the patient can sign the release form, friends and family may not sign for the patient. If you wish to receive a copy of your records the fee is $10.00. Payment must be received prior to the release of records. There is no fee if records are being released to another provider.

STATEMENTS & PAST DUE ACCOUNTS

You will receive a statement if there is an outstanding balance. The billing statement will itemize your services as well as any payment, deductibles, or co-insurance amounts applied by your insurance company. If you do not understand your statement or have questions regarding your balance, please contact our billing office at 304-766-4300. In the event your balance becomes past due, the account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with our collection agency and possible termination from our practice.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any problems with our practice manager so that we can assist you in the management of your account.

I understand that I am a patient of Patel & Patel, M.D., Inc. and that as a patient of this practice I have responsibilities. I understand that it is my responsibility to keep scheduled appointments and make the office staff aware of any change of address, telephone number or insurance information. I understand that failure to comply with the above mentioned responsibilities means the Doctors Patel, their associates and staff cannot be held responsible for follow-up of any labs, x-rays, pap smears or delay of treatment.

Print Name:_____

Patient Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____