Chart Number

WILLIAMS COMPREHENSIVE HEALTHCARE PLLC

PATIENT REGISTRATION

(This information is needed to properly file your insurance. Please answer completely and print neatly. Questions should be answered in the space below the question. Any inaccurate or incomplete information may result in a denial by your insurance company and you being billed personally for services.)

Date

PATIENT INFORMATION

Patient's Social Security #

PATIENT: Last Name	First Name	M.I.	Preferred Prefix		Sex
			Mr.	Ms.	
			Mrs.	Miss	

Street Address	Birthdate	Age

City	State	Zip Code	Home Telephone	Mobile Telephone	Work Telephone

Employer	Employer's Address	Occupation	Marital Status

E-Mail Address	OTHER CONTACT: Name	Relationship	Telephone Number

In case of emergency, who may we contact who does not live with you?		What is your preferred pharmacy?	
Name	Telephone Number	Name	Telephone Number

RESPONSIBLE PARTY

(Complete this section if you are listed as a dependent on someone else's insurance)

Responsible Party's Social Security #

IS THIS THE RESPONSIBLE PARTY FOR:
_____PRIMARY INSURANCE _____SECONDARY INSURANCE _____BOTH

RESPONSIBLE PARTY: Last Name	First Name	M.I.	Preferred Prefix		Sex
			Mr.	Ms.	
			Mrs.	Miss	

Street Address	Birthdate	Relationship To Patient

City	State	Zip Code	Home Telephone	Work Telephone

Employer	Employer's Address	Marital Status

PLEASE ALSO COMPLETE THE REVERSE SIDE OF THIS FORM.

INSURANCE INFORMATION

Please provide our front desk with your insurance card so that it may be copied. Thank you.

PRIMARY INSURANCE

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Street Address for claims:	City	State	Zip	Telephone Number

Please specify your insurance company's preferred lab. (N/A for Medicare)	Is Prior Authorization Required for Care?

SECONDARY INSURANCE

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Street Address for claims:	City	State	Zip	Telephone Number

IF YOUR INSURANCE IS AN HMO, PPO, MCO, MEDICARE ADVANTAGE PLAN OR OTHER MANAGED CARE POLICY, PLEASE READ AND SIGN BELOW: I understand that each insurance contract is personal to the insured and that it is my responsibility to know the terms of my plan. I have checked with my insurance company and verified that I am authorized to see the providers in this office; and that my insurance company will be pay for the services rendered. If a referral from another provider is required before seeing a provider of this office, I agree that it is my responsibility to obtain such a referral. I also agree to advise the office when my plan requires preauthorizations of any kind. If my insurance company limits the use of office based labs and testing and requires the use of outside facilities, I have listed them above.

If any charges remain unpaid because I have not provided the proper information, because I do not keep such information updated with this office or because my plan does not cover the charges, I agree to be personally liable for said charges. The above language does not apply to contractual adjustments of allowed charges under the plan. This statement remains in effect until I specifically revoke it in writing or until I all charges on my account are paid and I am no longer a patient.

_____ _____

Date **Patient/Responsible Party**

MEDICAL RECORDS CONFIDENTIALITY

My signature below indicates that I have been offered a copy of this office's Notice of Privacy Practices For Protected Health Information (Confidentiality Policy) for review. Unless I disagree below, I agree that my protected health information may used according to the policies itemized in the Confidentiality Policy. Without in any way limiting the scope of the Confidentiality Policy, I specifically agree the office may release my records to other health care providers involved with my care, prescriptions may be faxed to pharmacies, records may be released to any company who is expected to pay for services rendered to me and to companies involved in billing and collecting assigned claims and messages may be left at my home or on my personal cell phone concerning appointments and test results provided the individual answering the phone who identifies himself as an adult member of my family such as a spouse or parent. Messages may also be left on my home or personal cell phone answering machine. Further, any mobile number or email address may be added to social media accounts of this provider such as Facebook and Twitter provided no confidential medical information is shared. This statement remains in effect until I specifically revoke it in writing or until all charges on my account are paid and I am no longer a patient.

_____ _____

Date **Patient/Responsible Party**

My records may not be used according to the practice's privacy policies in the following ways:

_____

_____

How did you find out about us?

_____

_____

Is there any additional information we need to properly file your insurance?

_____

_____

_____