REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____ Date of Birth: _____
Last Name First Name Initial

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone: _____ Social Security#_____- ____- _____ Sex: M F Marital Status:_____

Cell Phone: _____ Employer: _____Work Phone: _____

PRIMARY INSURANCE INFORMATION Please provide copy of insurance card

Subscriber: _____ _____ Date of Birth: _____
Last Name First Name Initial

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone: _____ Social Security#_____- ____- _____ Sex: M F Marital Status:_____

Cell Phone: _____Relationship to Pt: _____Occupation: _____

Employer: _____ Work Phone: _____

Insurance Name:_____ Address: _____

Subscriber/ID # _____ Group #_____Effective Date: _____

SECONDARY INSURANCE INFORMATION Please provide copy of insurance card

Subscriber: _____ _____ Date of Birth: _____
Last Name First Name Initial

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone: _____ Social Security#_____- ____- _____ Sex: M F Marital Status:_____

Cell Phone :_____ Relationship to Patient: _____ Occupation: _____

Employer: _____ Work Phone: _____

Insurance Name:_____ Address: _____

Subscriber/ID # _____ Group # _____Effective Date: _____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician:_____**Referred by:** _____

Address: _____**City:** _____ **State:**_____**Zip:**_____

Person to Contact in An Emergency: _____Relationship:_____

Day Phone: _____ Evening Phone:
_____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr. Machtinger for services rendered. I have fully disclosed all information concerning the insurance/third-party benefits to which I am entitled. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand that if I fail to cancel my appointment with 24 hours notice, I will be charged a processing fee of a minimum of $25.00. I understand and accept that if my insurance company has not remitted payment within sixty (60) days of submission of the bill that I will then be billed directly with payment due immediately at that time. In the event of default, I agree to pay all cost of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature (Or Parent, if Minor): _____ Date: _____

FINANCIAL POLICY

PRIVATE INSURANCE PLANS

Co-pay amounts are due in full on your date of service. We will file your insurance claim as a courtesy to you. Deductibles and co-insurance will be billed to you after your insurance has paid in full.

Your insurance coverage is a contract between you, your insurance company and (if you are employed) your employer. If a dispute arises between you and your insurance carrier regarding copayments, deductibles or coverage for provider services we can only become involved to the extent of supplying factual information as required. **It is in your best interest to know and understand your benefits, deductibles, co-insurance amounts, etc. before you seek services.**

CASH PATIENTS

Full payment is expected at time of service. We will gladly discuss estimated medical care costs. Actual costs are determined by the medical care that your individual situation requires and as discussed directly with your medical provider.

HMO INSURANCE PLANS

We are contracted with HMO Plans thru Mills Peninsula Medical Group (MPMG/PAMF), Sequoia Physicians Network (SPN) and Direct Network. **Referrals from your primary care physicians are due at the time of service and are your responsibility to obtain. Any changes to your insurance carrier and or primary care physician will require you to obtain a new referral.**

CANCELLED APPOINTMENTS

This office requires twenty-four hour notice (72 hour notice for Monday appointments) for cancellation or rescheduling of appointments. **You may be charged for visits that are missed, cancelled or postponed without adequate notice.**

ACCEPTANCE AND ASSIGNMENT OF BENEFITS

I understand and accept that, regardless of my insurance status, I am responsible for the balance of my account for any medical care that has been provided by this practice. I have read the financial policy and have completed the Patient Registration Form. I certify that this information is true and correct to the best of my knowledge.

_____	_____
Signature of Responsible Party	Patient's Name if Different Person
_____	_____
Printed Name of Responsible Party	Date