

**COLONIAL FAMILY PRACTICE
PATIENT REGISTRATION FORM**

**PATIENT DEMOGRAPHIC INFORMATION
(This form is to be updated yearly or with any information change)**

PATIENT INFORMATION

PREFERRED PHARMACY				<small>(used for ePrescribe - Please be as specific as possible with the details, as this will be loaded into our system and prescriptions will be transmitted electronically when possible and/or allowed)</small>	
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
Email		Date of Birth		Sex	M F
Marital Status	S M W D SEP	SSN		Race	

RESPONSIBLE PARTY INFORMATION (If other than patient)

Relationship to Patient		<i>*This area is to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian...)</i>			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Work Phone		Cell Phone	
Date of Birth		SSN			

PRIMARY INSURANCE

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer <small>(For Medcost Preferred & Premier Health Only)</small>	
Policy Holder DOB		Policy Holder SSN			

SECONDARY INSURANCE

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer <small>(For Medcost Preferred & Premier Health Only)</small>	
Policy Holder DOB		Policy Holder SSN			

<u>EMERGENCY CONTACT</u>	Name		Phone #	
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Patient/Legal Guardian Signature:		Date	
CFP Employee Witness Signature		Date	

Financial Policy, Assignment of Benefits & Release

(Effective 01/01/2009)

Thank you for choosing Colonial Family Practice (CFP) to meet your medical needs. We are dedicated to providing the best treatment available. Our Patient Financial Policy is intended to describe our expectations regarding the payment for services we provide. Please read the below information carefully, initial each section and sign and date the bottom.

Missed Appointments: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment, or cancel with less than 24 hours notice. This fee must be paid before a new appointment is scheduled. You may be discharged from CFP if you have more than 3 Missed Appointments. [REDACTED]

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will have you meet with an account executive to set up a payment plan. Balances outstanding more than 30 days may bear interest at 18% per annum or 1.5% per month. If you have an outstanding patient balance over 90 days old and have failed to make appropriate payment arrangements with our Business Office, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to make agreed upon payments, your account may be turned over to a collection agency. Accounts assigned to Collections may be charged a \$ 50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. [REDACTED]

Returned Checks: There is a \$30.00 fee for returned checks. This fee plus your balance is due the next day after you are notified of the returned check. [REDACTED]

Insurance: CFP participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is credentialed with them.

Valid Driver's License and Insurance Cards must be presented at your initial visit. *INSURANCE CARDS MUST BE PRESENTED AT EVERY VISIT. IF YOU DO NOT HAVE YOUR UP-TO-DATE INSURANCE CARD WITH YOU, WE WILL BE HAPPY TO RESCHEDULE YOUR APPOINTMENT OR CLASSIFY YOUR APPOINTMENT AS SELF-PAY.* Self-Pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving.

It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full.

If your insurance company does not pay the practice within a reasonable period, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill.

Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit.

CO-PAYS MUST BE PAID PRIOR TO SERVICES BEING RENDERED. Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment.

DEDUCTIBLES AND CO-INSURANCE FEES MUST BE PAID AT CHECK-OUT. ALL PATIENTS MUST STOP AT THE CHECK-OUT PRIOR TO LEAVING TO PAY FOR SERVICES RENDERED. Patients who are unable to pay for the services as required by insurance will be required to meet with an account executive to set up a payment plan. [REDACTED]

Assignment of Benefits & Release of Information:

I hereby authorize treatment of myself or the minor described above. I request payment from my insurance company be made to CFP. I understand that I am ultimately responsible for the balance of my account. I hereby authorize the Physician, Nurse Practitioner or Allied Health Care Provider in charge of my care to administer any treatment deemed necessary in the diagnosis and/or treatment of my medical condition. I authorize the release of all medical information necessary to process this claim through my insurance carrier. I also authorize payment of medical benefits to CFP. If receiving a physical exam for employment, I authorize the release of the results of my exam to my prospective employer.

Signature of Patient or Responsible Party _____

Date: _____

Signature of CFP Employee Witness _____

Date: _____