Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Relation to Patient _____ Guarantor Email _____

Patient Information

Name _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ Email _____
Date of Birth _____ Sex _____ Marital Status _____
Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native
❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined
Ethnicity: ❑ Hispanic or Latino ❑ Not-Hispanic or Latino ❑ Unknown ❑ Declined
Primary Language _____
Social Security Number _____
(If a minor): Mother's Name _____ Home Phone # _____
Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____
Relationship to Patient _____
Address _____
City, State, ZIP _____
Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Name _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Name _____
Group # _____ Policy # _____
Subscriber Name _____
Patient Relation to Subscriber _____ Date of Birth _____
Social Security Number _____
Employer _____ Work Phone # _____

Referred by _____

Signature _____ Date _____ Time _____

PATIENT REGISTRATION & INSURANCE INFORMATION

Patient Name:
Date of Birth:
Medical Record #:
Financial #:

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance/Billing Information

- As a courtesy, we will file your insurance claim on your behalf. You are responsible for any patient portion at the time of your visit. If we do not participate with your insurance plan or you are uninsured, you will be responsible for full payment at the time of your visit. In the event that your insurance company does not pay our claim, then the ultimate payment responsibility rests with the patient.
- We use an electronic invoicing process to notify you of any outstanding personal balances.
- Once you receive your first e-statement, you will also gain access to our online bill pay service to quickly and easily resolve your account.
- To assist with timely payment, please notify the office personnel of any changes to your insurance policy, and mailing or e-mail addresses. Unresolved patient balances could be referred to a collection agency and the patient is responsible for any additional costs incurred.
- Accepted Methods of Payment: **Cash, Check, Visa, Mastercard, Discover, American Express**.

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. A properly executed Authorization and Consent to Treat form must be on file before we can provide healthcare services or treatment to a minor patient.

Completion of Forms

Baptist Health reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Treatment and Payment

I consent to examination, diagnosis and general medical care and treatment to be performed by office personnel, including physicians, nurses and assistants.

Patient or Parent (Legal Guardian)	Date	Time

I hereby authorize Baptist Health to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

Responsible Party Signature	Date	Time

Patient's Name (Please Print)	Date of Birth

Notice of Privacy Practices

I acknowledge receipt of a copy of the Baptist Health Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at Baptist Health, I authorize Baptist Health to use and disclose information from and release copies of my (the patient's) medical records in accordance with Baptist Health's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

Patient or Parent (Legal Guardian)	Date	Time

AUTHORIZATIONS AND ACKNOWLEDGMENTS

Patient Name:

Date of Birth:

Medical Record #:

Financial #: