

REGISTRATION FORM 2011

NVPCCA, P.C.

PATIENT REGISTRATION *(Please Print)*

Date: _____

PATIENT NAME				FIRST	M.I.	LAST		HOME PHONE NO. ()
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	AGE	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> O		SOCIAL SECURITY NUMBER			WORK PHONE NO. ()
ADDRESS Street				Apt.	City	State	Zip	CELL PHONE NO. ()
ARE YOU <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student						OCCUPATION		
EMPLOYER OR SCHOOL NAME & ADDRESS				Street	Suite	City	State	Zip
E-MAIL ADDRESS				MAY WE SEND YOU INFORMATION VIA EMAIL, SUCH AS REMINDER NOTICES? <input type="checkbox"/> Y <input type="checkbox"/> N				

PRIMARY INSURANCE COMPANY				INSURED (If other than patient please complete)			
INSURANCE COMPANY NAME OR MEDICARE INFORMATION				POLICYHOLDER (Insured)		SOC. SEC. NO. OF POLICYHOLDER	
POLICY NUMBER		GROUP NUMBER		INSURED'S ADDRESS Street			
INSURANCE COMPANY ADDRESS Street				City		State Zip	
City		State Zip		PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
INSURANCE COMPANY PHONE NUMBERS Verifying () Claim ()				IS THIS INSURANCE PLAN THRU YOUR EMPLOYER? <input type="checkbox"/> Y <input type="checkbox"/> N		EMPLOYER'S NAME & PHONE NO.	

SECONDARY INSURANCE COMPANY				INSURED (If other than patient please complete)			
INSURANCE COMPANY NAME OR MEDICARE INFORMATION				POLICYHOLDER (Insured)		SOC. SEC. NO. OF POLICYHOLDER	
POLICY NUMBER		GROUP NUMBER		INSURED'S ADDRESS Street			
INSURANCE COMPANY ADDRESS Street				City		State Zip	
City		State Zip		PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
INSURANCE COMPANY PHONE NUMBERS Verifying () Claim ()				IS THIS INSURANCE PLAN THRU YOUR EMPLOYER? <input type="checkbox"/> Y <input type="checkbox"/> N		EMPLOYER'S NAME & PHONE NO.	

THIRD INSURANCE COMPANY				INSURED (If other than patient please complete)			
INSURANCE COMPANY NAME OR MEDICARE INFORMATION				POLICYHOLDER (Insured)		SOC. SEC. NO. OF POLICYHOLDER	
POLICY NUMBER		GROUP NUMBER		INSURED'S ADDRESS Street			
INSURANCE COMPANY ADDRESS Street				City		State Zip	
City		State Zip		PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
INSURANCE COMPANY PHONE NUMBERS Verifying () Claim ()				IS THIS INSURANCE PLAN THRU YOUR EMPLOYER? <input type="checkbox"/> Y <input type="checkbox"/> N		EMPLOYER'S NAME & PHONE NO.	

EMERGENCY CONTACT NAME			RELATIONSHIP TO PATIENT			EMERGENCY CONTACT PHONE NO. ()		
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FAMILY DOCTOR		FAMILY DOCTOR PHONE NO. ()		REFERRING DOCTOR		REFERRING DOCTOR PHONE NO. ()	
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IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THE FOLLOWING:

ACCOMPANYING ADULTS NAME		RELATIONSHIP TO PATIENT		SIGNATURE	
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TO ALL PATIENTS:

RELEASE OF HEALTH INFORMATION

I understand that NVPCCA may use and disclose my health information for those purposes disclosed in NVPCCA's Notice of Privacy Practices, a copy of which I may obtain upon request. I authorize NVPCCA, or its physicians to transmit my health information electronically, via U.S. mail, or facsimile in conformance with NVPCCA's Notice of Privacy Practices or pursuant to an authorization. I release NVPCCA and its physicians from any liability associated with a misdirection of transmission or communication of health information, or failure to receive such a transmission or communication via any medium.

ASSIGNMENT OF BENEFITS – 2011

I hereby authorize any insurance carrier with whom I have a policy to pay directly to NVPCCA any benefits of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to NVPCCA are not paid after reasonable notice, that account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collections fees and interest due on amounts in default, including court costs and attorney's fees. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees and interest due on amounts in default. If a check is returned by the bank for insufficient funds I agree to pay the returned check fee of \$35.00 in addition to the balance owed.

Signature of Patient or Patient's Representative

Date

TO MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits which are payable to me, be paid directly to NVPCCA or its physicians, on my behalf, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to be released to the centers for Medicare and Medicaid Services to determine these benefits or the benefits payable for related services.

Signature of Patient or Patient's Representative

Date

MEDIGAP BENEFITS: I request that payment of authorized Medigap benefits which are payable to me, be paid directly to NVPCCA or its physicians, on my behalf, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to be released to my health insurance carriers (*as listed above*) and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Patient's Representative

Date

NO SHOW POLICY AGREEMENT

I understand that if I fail to provide a 24 hour notice to cancel an appointment or do not show up for an appointment I will be charged a fee for that missed appointment. The fee schedule is as follows:

1st No Show: No fee, Counseling given

2nd No show: \$50.00

3rd No Show: \$100.00 fee and possible discharge from practice.

Signature of Patient or Patient's Representative

Date

A copy of this form may be used in place of the original. I may revoke any or all authorizations at any time, except when action has been taken in reliance on this authorization. This authorization will expire on January 1st, 2014 unless otherwise revoked by me in writing.