MidValley Family Practice PC

Registration Form

Today's Date_____

Patient Name _____
Last Name
_____
First Name **Middle Initial**

Preferred Name _____

Social Security Number _____- _____- _____
Address (Physical) _____
City _____**State** _____ **Zip** _____
Address (Mailing) _____
City _____**State** _____ **Zip** _____
Age ____ **Date of Birth** _____ **Sex** ___ **F** ____ **M**
___ **Married** ___ **Widowed** ___ **Single**
___ **Separated** ___ **Divorced**
Race (check one):
_____American Indian or Alaskan Native
_____Asian _____ Black or African American
_____Caucasian _____ Hispanic or Latino _____Multiracial
Ethnicity (check one):
_____Hispanic or Latino _____Non-Hispanic or Latino
_____Other
Preferred Language _____
Employer Name_____
Employer Address _____
Employer Phone_____

Guarantor Information
(Person legally responsible for payment if different from the patient)

Guarantor Name _____
Last Name
_____
First Name **Middle Initial**

Address_____
City _____**State**_____ **Zip**_____
Relationship to patient _____
Social Security Number _____ _____ _____
Date of Birth_____
Guarantor Employer_____

Name of Insurance_____

Policy Number/ID # _____

Group # _____

Effective Date on Policy _____

Name of Subscriber/Policy Holder:
_____
Is patent covered by additional Insurance?
_____**Y** _____**N**

If Yes, list information:

Name of Insurance _____

ID # _____**Group #** _____

Effective Date on Policy _____

Name of Subscriber/Policy Holder:
_____

Assignment and release

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to MidValley Family Practice all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. MVFP may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related service.

_____
Signature or Patient, Parent, Guardian

_____
(Please print name of patient, Parent, Guardian)

_____
(Relationship to Patient)

Patient Phone:

Home (_____) _____ ***Work (_____)*** _____ ***Cell (_____)*** _____

Patient EMAIL _____

Emergency Contact Name _____ ***Relationship*** _____

Emergency Contact Phone:

Home (_____) _____ ***Work (_____)*** _____ ***Cell (_____)*** _____

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Patient Billing Agreement

1. I verify that the information on the reverse side has been reviewed and is correct.
2. I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and payment in full will be due immediately.
3. I understand that MVFP will file a claim with my insurance company, and that I am responsible for following up with my insurance company to ensure my claim is paid within 60 days of my visit date.
4. I understand that under the terms of the contract that I have with my insurance company, I must pay any pre-determined co-payment at every visit.
5. I understand that it is MVFP policy to charge in advance for deductibles and co-insurance.
6. If I have insurance with which MVFP IS NOT contracted, this is to include Motor Vehicle Accident and Liability Insurances; I agree to pay my bill in full at the time services are provided. This will be an estimated amount due until your services have been calculated by the billing department. I understand that MVFP will file a claim with my primary insurance carrier as a courtesy, but that it is my responsibility to follow up with my insurance company to ensure my personal reimbursement. I understand that MVFP cannot act as an intermediary between me and my insurance company to effect payment. I further understand that it is my responsibility to verify insurance coverage for the services provided by MVFP and that I will be personally responsible for the costs of services not covered by my insurance or any other third party.
7. If I am a patient with NO insurance coverage, I agree to pay my balance in full at the time services are rendered. This will be an estimated amount due until your services have been calculated by the billing department.
8. Workers' compensation laws require the employee to report injuries to their employer. Please make sure you have done this. You must notify us of the date of injury, claim number, insurance company name and address, phone number, and the adjuster's name. If your workers' compensation claim is denied or you do not provide the required information, you are responsible for payment at the time of service.
9. I hereby request and authorize MidValley Family Practice physicians and personnel to deliver medical care to myself or my dependents listed on the reverse side of this form.
10. Prior to, or during, my appointment physician may determine that additional tests or procedures are necessary in order for physician to be able to provide the level of care deemed appropriate by the physician for the patient's health and well being. Patient will be advised before any such tests or procedures are performed and will have the opportunity to have the necessity and cost of such tests or procedures explained. **Patient specifically acknowledges that MVFP cannot verify insurance coverage for any such tests or procedures. Additionally, patient acknowledges the real chance that his/her employer, insurance company and/or any other third party may not pay for such tests or procedures and patient agrees that he/she is personally authorizing these tests and that patient will be financially responsible for them in the event that they are not paid for in full otherwise.**
11. I hereby authorize the release of medical information to my insurance company (ies) concerning any illness and treatment.
12. I understand that a **$50.00 fee will be charged for adult physical (well-visit, pre-op) appointments missed or not canceled at least 24 hours in advance.**
13. I understand that a **$25.00 fee will be charged for child physical (well-child visit) and any other appointments missed or not canceled at least 24 hours in advance.**
14. If you have an outstanding balance you are expected to make payment or payment arrangements before your next scheduled appointment. Nonpayment may result in discharge from the practice.

_____ _____-_____-_____ ← *Sign*

Patient or Legal Guardian Signature Date:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received MidValley Family Practice's Notice of Privacy Practices.

_____ _____-_____-_____ ← *Print*

**Name of Patient (Please Print) ** Date of Birth (MM-DD-YY)

_____ _____-_____-_____ ← *Sign*

Signature of Patient or patient representative Date

DOCUMENTATION OF GOOD FAITH EFFORTS – Office Use Only

The patient presented to the office on _____-_____-_____ (date) and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of receipt of the Notice. However, such acknowledgment was not obtained because:

- ☐ Patient refused to sign HIPAA acknowledgement and/or present photo id.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

_____ _____-_____-_____

Signature of Employee Completing form Date