

Patient Registration Form

DATE _____

REFERRING DOCTOR _____

PATIENT INFORMATION

NAME LAST	FIRST	MI	SEX (CIRCLE) M F	DRIVER'S LICENSE #
HOME PHONE ()	SS#	D.O.B.	Mo. / Day / Year	SPOUSE'S NAME
EMPLOYER	WORK PHONE ()		EXT.	MARITAL STATUS S D Y M W STUDENT N
HOME ADDRESS		CITY	STATE	ZIP
E-MAIL ADDRESS	BEEPER NO.()		CELL PHONE NO.()	
EMERGENCY CONTACT: (NOT LIVING WITH YOU)	RELATIONSHIP		EMERGENCY PHONE ()	EXT.

RESPONSIBLE PARTY (If Not Patient)

NAME LAST	FIRST	MI	RELATIONSHIP
SS#	D.O.B.	Mo. / Day / Year	DRIVER'S LICENSE #
HOME PHONE()	WORK PHONE ()		EXT.
CELL #() BEEPER #()			
HOME ADDRESS		CITY	STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH	SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT	
EMPLOYER	WORK PHONE		EXT.
SECONDARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH	SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT	
EMPLOYER	WORK PHONE		EXT.

I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Maternal Fetal Medicine. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

Date _____ Signature _____

PATIENT NAME _____ DATE _____

MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION (Medicare Patients Only)

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIANS OF BROOKWOOD MATERNAL FETAL MEDICINE FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS FOR RELATED SERVICES.

PATIENT SIGNATURE

DATE

PERSON OTHER THAN PATIENT

RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES RECEIPT

I HAVE RECEIVED AND REVIEWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY BROOKWOOD MATERNAL FETAL MEDICINE.

PATIENT SIGNATURE

DATE

FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO BROOKWOOD PRIMARY CARE NETWORK, INC. I UNDERSTAND BROOKWOOD MATERNAL FETAL MEDICINE WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45 DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT BROOKWOOD PRIMARY CARE NETWORK, INC. MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

PATIENT SIGNATURE

DATE