Registration

Name ___________________________, ___________________________ ____________________
Last First Maiden (if applicable)

Address ____ ______________________
Street Address APT #

____
City State ZIP

Home Phone _________________________ Cell # ________________________

Social Security__________________________ Date of Birth ____________________

Marital Status: S M D W Occupation_________________________________

Primary Insurance____ Copay $_________
*Please provide a copy of your card to the front desk

Policy Number_____________________________________ Group _____________________

Policy Holder__________________________________ SELF / SPOUSE / PARENT / OTHER___________

Date of Birth ________________ SS#_________________________

Secondary Insurance____ Copay $_________
*Please provide a copy of your card to the front desk

Policy Number_____________________________________ Group _____________________

Policy Holder__________________________________ SELF / SPOUSE / PARENT / OTHER___________

Date of Birth _______________ *SS#*______________________

Registration (Contd.)

I hereby assign and transfer to Island Medical Care, all my rights and interests in medical reimbursement benefits under my insurance policy. I understand that I am responsible for all charges regardless of my insurance coverage. I authorize the release of my medical information for purposes of insurance processing.

PATIENT SIGNATURE ___________________________________ *DATE* _______________

Emergency Contact ___________________________________ _____________________

Name *Phone Number*

Previous Primary Care Dr ____

Medication Allergies ____

Pharmacy ____ ______________________

Name *Address* *Phone Number*

Release of Information: I give ISLAND MEDICAL CARE, PLLC *permission to discuss any information including all my medical records, test results or medical advice with the following individuals:*

_____________________________ ____________________ _______________

Name *Phone Number* *Relationship*

Registration (Contd.)

How did you hear about our office? ____

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will bill your insurance company for services rendered. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. We will attempt to verify benefits for specialized services we perform; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

Most Insurance plans will permit the direct assignment of your benefits to our office. We accept insurance assignment. YOU ARE RESPONSIBLE FOR ANY FEES YOUR INSURANCE DOES NOT COVER. This includes co-payment, co-insurance and yearly deductibles. Our office will make every effort to collect appropriate payment from your insurance company. However, if your insurance company fails to make payment within 120 days, the balance of your bill will become your responsibility. Patients are expected to make their co-payments immediately after they have been treated. 24 hours notice is required for all cancelled/rescheduled appointments. There is a cancellation fee ($25.00) for missed appointments where notice has not been given. This fee will be billed directly to the patient. There is a service fee of $25 for all returned checks. There is a $10.00 charge for medical forms to be completed by the doctor.

Patient Signature ____________________________________ *Date*__________________