PATIENT REGISTRATION FORM

***Today's Date:* _____ *Clinic Name:* _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#:** _____

***Employer Name and Address:** _____

_____ **Work Phone #: (_____) _____-_____**

E-mail Address: _____ **Cell Phone #: (_____) _____-_____**

Emergency Contact Name: _____ **Emerg Phone #: (_____) _____-_____**

Please tell us how you heard about us: _____ ***Referred by*** _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other** _____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex: Female _____ Male _____**

***Employer Name and Address:** _____

_____ **Work Phone #: (_____)_____-_____**

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

Insured's Social Security #: _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ **Eff Date:** _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

***Insured's Social Security #:** _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ *** Eff Date:** _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

Please read and sign back of form.

BIG COUNTRY INTERNAL MEDICINE, PLLC PRIVACY AND BILLING PROCEDURES AUTHORIZATION AND ACKNOWLEDGEMENT

These authorizations/acknowledgments cover all services rendered to me or the patient I am signing for today and for all future dates of service. I understand I may revoke this authorization by informing Big Country Internal Medicine, PLLC (BCIM) in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by BCIM.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AUTHORIZATION TO RELEASE INFORMATION TO FRIENDS/FAMILY/OTHERS

I have received a copy of Big Country Internal Medicine, PLLC Notice of Privacy Practices. I authorize BCIM to release any information regarding my treatment, including lab results and medical records, to the following individuals/entities (BCIM may not release information or records to the names individuals/entities unless you identify them here):

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

DJIM will use my home phone number and primary address supplied during registration to contact me regarding my treatment, including lab results, and medical records. I will ensure this information is up to date at every visit.

AUTHORIZATION TO TREAT AND BILL

I consent to be treated by Big Country Internal Medicine, PLLC. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize BCIM to bill my medical insurance for the care I receive and to release any information that the insurance carrier may require to process this bill. I authorize payment of medical benefits to BCIM, or to outside labs as described below, for all services performed and billed by BCIM. I understand that I am responsible for all charges for the treatment I receive at BCIM. I understand that BCIM providers may utilize the Prescription Monitoring Program service at no additional charge to me.

As a courtesy, BCIM will bill my medical insurance. If I do not provide complete and accurate insurance information to BCIM, I understand BCIM may not receive payment from my insurance carrier and I will be responsible for the bill in it's entirety. After my insurance carrier submits payment to BCIM, I understand that I may owe BCIM for services not covered by my insurance carrier and I agree to pay BCIM for those services promptly. BCIM may send lab specimens to an outside (third party) laboratory for analysis. I authorize any lab performing services on my behalf to bill my medical insurance for outside lab services. I understand that my medical insurance may not pay for all services provided by the laboratory and I agree to pay any remaining balance to the laboratory performing services on my behalf. I understand that BCIM is not responsible for payment to outside labs for tests performed on my behalf.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, BCIM may choose not to bill my insurance and may decline credit/debit card transactions, or checks as a form of payment. I understand that if I fail to make payment to BCIM for services provided to me, the balance owed may be sent to a collection agency and I may incur collection fees in addition to the amount owed for services/treatment rendered. I understand that I may contact BCIM to make payment arrangements that may prevent this additional cost.

Signature _____ Date _____

Patient Name _____ Patient's Date of Birth _____

Patient Guarantor * _____ Relationship to Patient * _____

* Required if the patient is a minor or if the patient is unable to sign this form