

Fremont Family Practice Registration Form

Personal Information			
Last Name	First Name	MI	
Person responsible for bill if not patient			
Address			
City	State	Zip	
Home Phone ()	Cellular Phone ()	Copy of Driver's License required <input type="checkbox"/>	
Date of Birth	Gender M F	Social Security Number required	Marital Status
PATIENT Employer (or student status)		PATIENT Work Phone ()	ext
Email: _____ Spouse's name /Parent if minor			
Mandatory Insurance Information			
	Primary Insurance	Secondary Insurance	
Insurance Name Through Employer? Y N			
Subscriber's Name Same address as above? Y N			
Subscriber's Birth date and sex: M or F			
Relation to Subscriber: child, spouse, self, other			
Policy Number			
Group, Member or Claim Number			
Effective Date			
Co-payment Amount-may not be printed on card, contact your insurance to confirm			
Is this policy a Short term policy? Y N If this is new coverage please list your pre-existing condition time frame _____			
Is your insurance a managed care plan that requires a primary care doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, who is your primary care doctor? _____			
If you are on Medicare are you currently working or is your spouse working? Y N			
Referred to this office by:			
Emergency Contact someone not currently living with you			
Name	Relationship	Phone Number ()	

I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance coverage is **NOT a guarantee** of payment for services provided by my healthcare provider including preventive, routine screening, vaccinations, or procedures considered cosmetic in nature. It is **my responsibility to understand my insurance benefits**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. **Co-payments mandated by my insurance company may not be printed on my insurance card. I understand the Co-payments are due at the time of service.** It is my responsibility to notify the receptionist upon arrival that a co-payment is due. A **\$20.00** handling fee will be added to my statement in circumstances when I have not paid at the time of service. I have been informed that NSF's for checks or credit card payments are subject to a **\$25.00** handling fee for each submission. A **NO SHOW** appointment without 24 hours advance notice is subject to a **\$40.00** fee. I have been informed that payment is due upon the receipt of my monthly statement. Should I have **NO** insurance I understand that payment is due in full at the time of service.

Patient Signature

Date