Colonial HEALTHCARE

Chart #: _____

Patient Registration Forms

Today's Date:	Preferred Pharmacy: (This will be used to electronically send your prescriptions when possible)

PLEASE PRINT

Patients Last Name: First: M.I.	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) S / M / D / Sep / W
Street Address:	City/State:		Zip Code:
Home Phone No.: ( )	Cell Phone No.: ( )		
Birth Date: / /	Sex:	Race:	SSN: - -
Employer:	Employer Phone No.: ( )		Occupation:
E-mail Address:	Driver's License Number:		

PRIMARY INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Person Responsible for Bill:	Birth Date: / /	Policy Holders SSN: / /	Policy Holders Name:
Name of Primary Insurance:	Policy No.:	Group No.:	

Patients relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

SECONDARY INSURANCE INFORMATION

(If applicable)

Policy Holder Name:	Birth Date: / /	Policy Holder SSN: - -
Name of Secondary Insurance:		Patients relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other
Policy No.:		Group No.:

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:	Relationship to Patient:
Home Phone No.: ( )	Cell Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ***Colonial Healthcare*** or insurance company to release my information required to process my claims.

X _____ X _____

Patient / Guardian Signature: ***Today's Date:***

CFP Employee Witness Signature: ***Date:***

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Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Colonial Family Practice (CFP) to meet your medical needs. We are dedicated in providing the best treatment available. **Please read the below information carefully, initial and date all sections.**

Patient Consent for Treatment

I voluntarily consent to all health care treatment and diagnostic procedures provided by Colonial Healthcare and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that no guarantee has been or can be made as to the results of treatments or examinations at Colonial Healthcare. **Initials_____**

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I request payment from my insurance company be made to CFP. I understand that I am ultimately responsible for the balance on my account.

I authorize the release of all medical information necessary to process claims through my insurance carrier. I also authorize payment of medical benefits to CFP. If receiving a physical exam for employment, I authorize the release of the results of my exam to my employer.

I authorize CFP to obtain all my medication/prescription history when using an electronic system to prescribe medications.

Initials_____

Financial Policy

MISSED APPOINTMENTS: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment or cancel with less than 24 hours' notice. This fee must be paid before a new appointment is scheduled. You may be discharged from CFP if you have more than 3 Missed Appointments.

ACCOUNT BALANCES: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will have you speak with a representative to set up a payment plan. If you have an outstanding patient balance over 75 days old and have failed to make appropriate payment arrangements with out Billing Office, your account may be turned over to an outside collection agency. Accounts assigned to Collections may be charged a $50.00 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. **Initials_____**

RETURNED CHECKS: There is a $30.00 fee for returned checks. This fee plus your balance is due the next day after you are notified of the returned check. **Initials_____**

INSURANCE: CFP participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is credentialed with them. A **Valid Driver's License** and **Insurance Cards must be presented** at each visit. If you do not have your up to date insurance card, we will be happy to reschedule your appointment of classify your appointment as self-pay.

SELF-PAY PATIENTS AND PATIENTS WHO HAVE NOT MET THEIR DEDUCTIBLES are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we must file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. If your insurance company does not pay the practice within a reasonable period, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare and other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. **Co-pays must be paid PRIOR to services being rendered.** Your insurance company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. **Deductibles and co-insurance fees must be paid at check-out.** Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.

Initials _____

Signature of Patient or Responsible Party: _____ **Date: _____**

Signature of CFP Employee Witness: _____ **Date: _____**