

Patient Registration Form & Financial Policy

First Name _____ MI _____ Last Name _____

Birth Date _____ SS# _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cell _____

Circle preferred number to use for calls and messages: (we never reveal the subject)

Home | Work | Cell

I was referred to this office by: (check one or more below)

- Camelback Family Planning Site
- Gynpages.com (ACOL)
- National Abortion Federation (NAF)
- Yellow Pages
- Referred by Doctor (Name: _____)
- Referred by a friend
- I have been here before
- Other _____

Employer _____ Occupation _____

Emergency Contact Name & Phone#s _____

Authorization

I hereby request the direct payment of medical benefits be made to Gabrielle Goodrick, M.D. (Jackrabbit Family Medicine, P.C.) for any services rendered to me. I authorize any holder of medical information about me to release this information to my insurance carrier or its intermediaries, to the Health Care Financing Administration and its agents, to my attorney, or to another physician’s office. I understand that because these services are performed for me, I am financially responsible for all charges whether or not paid by my insurance carrier. If payment is fully or partially denied, I understand that my insurance carrier expects the practice to bill me directly for services rendered, and I agree to be personally and fully responsible for payment. If I fail to pay the balance of my account in a timely manner, I understand that my account may be turned over to a collection agency. I agree to pay all costs associated with this action including collection fees, attorney fees, and any court costs.

Patient Signature

Date