

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

Insurance Carrier _____ Plan Type: _____

Policy Holder _____ Policy # _____ Group# _____

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 _____

Insurance Billing Policy

Patient with active health insurance must have benefits verified before each visit. Third-party billing is offered with the following conditions: 1) Co-payment, co-insurance, and any unmet deductible are due at the time of service. These may not be the actual charge once the claim has been processed by your insurance carrier. You may receive a refund or a balance bill. 2) Patients must provide insurance card and photo identification at each visit. 3) Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim.

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