

# Patient Registration



# Heritage Family Medicine.Com

*It is not necessary to complete portions of this form previously submitted online.*

## Patient Information

Check here if patient is also guarantor (person responsible for payment)

Circle: M F TG Marital Status: S M D W P

BD (mm/dd/yy)/Name (L, F,MI): \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Relationship to Guarantor (the person responsible for payment): \_\_\_\_\_

Relationship to Primary Insured: \_\_\_\_\_

## Insurance Information

**(Please present card(s) to receptionist upon completion of registration)**

Primary Insurance: \_\_\_\_\_ Co-pay: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Insured ID Number: \_\_\_\_\_ Insured Group Number: \_\_\_\_\_

Insured's Full Name: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Secondary Insurance

Secondary Insurance: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Insured ID Number: \_\_\_\_\_ Insured Group Number: \_\_\_\_\_

Insured's Full Name: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Guarantor**

**(Person Responsible For Payment)**

**Complete only if NOT the same as patient.** (If the same put a check mark at "Patient Information")

Full Name (FIRST, Last, MI): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Relationship to Primary Insured: \_\_\_\_\_

PATIENT BD (mm/dd/yyyy): \_\_\_\_\_

PATIENT Name (Last, First, MI): \_\_\_\_\_



## Consent, Assignment of Benefits, Financial Responsibility

I hereby consent, for myself or my dependent, to all medical treatment ordered by the professional staff of Heritage Family Medicine (HFM).

I fully understand and agree that I am responsible for full payment for medical services rendered by HFM to me or my dependent, and that such payment will not be delayed or withheld because of any insurance coverage or pendency of claims thereon. I understand that it is my responsibility and not that of HFM to know which procedures my chosen insurance company may cover or approve. If my insurance company has for any reason refused to pay 100 percent of HFM charges within ninety (90) days of any and all appeals or requests for information, I will pay HFM in full for any balance yet due, except to the extent HFM has waived that claim in full or in part with Regence, First Choice, Uniform, Aetna, DSHS, Molina, Medicare, and other third parties with whom HFM may be directly contracted.

As a courtesy to me, HFM will submit its charges, first, to most insurance companies and I hereby assign all proceeds of such billing to HFM. I authorize the release of any medical or other information necessary to process such claims. Further, in pursuit of such claims, I authorize HFM to be my personal representative, which allows HFM to: (1) submit any and all appeals if my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I also agree that any fines levied against my insurance company will be paid to HFM for acting as my personal representative.

Should my payment mechanism change or not be as reported on my Patient Registration Form, I further understand that HFM may, with 30 days notice, be compelled to discontinue my care.

HFM is not a lending institution. It does not intend to extend credit to any patient. Doing so raises the cost of care for everybody. However, as it is impossible to know what amounts will be paid by insurance companies until they have completed their processing, some portion of the original bill will often be transferred to the patient. All amounts that become my personal responsibility are due and payable in full, immediately upon receipt of the statement upon which they first appear. Any amount not paid and thus requiring additional billing will be charged the greater of \$10.00 or 1.5% of the outstanding balance for each subsequent monthly statement. In the event of collection efforts, including but not limited to legal action, should it become necessary to collect any unpaid balance, I agree to pay the reasonable costs of collection, including but not limited to attorney's fees. HFM *really* does expect prompt payment.

HFM sees patients by appointment only - a valuable commodity that cannot be used by others when my dependant or I fail to keep or are significantly late. Such behavior results in higher costs and inconvenience to all other patients. A fee of \$40.00, payable before any further appointments are accepted, may be charged if I fail to cancel an appointment with at least 4 hours notice or am late by more than 15 minutes and must be rescheduled.

I am familiar with HFM financial policies and HFM Privacy Policies and know they are available in full at [www.heritagefamilymedicine.com](http://www.heritagefamilymedicine.com).

The above declarations, to which I have given my full assent, will remain in effect throughout my relationship with HFM or until succeeded by a subsequent declaration.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Date