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: ______________________

Primary Insurance & Policy Holder Information (Please present card(s) to receptionist upon completion of registration)

Primary Insurance: ______________ Co-pay: ______________

Billing Address: ______________________

Subscriber's ID Number: ______________ Subscriber's Group Number: ______________

Subscriber's Full Name: ______________________

Subscriber's Birth date: ______________ Subscribers 's Social Security #: ______________

Subscriber's Employer: ______________ Effective Policy Date: ______________

Secondary Insurance & Policy Holder Information

Secondary Insurance: ______________________

Billing Address: ______________________

Subscriber's ID Number: ______________ Subscriber's Group Number: ______________

Subscriber's Full Name: ______________________

Subscriber's Birth date: ______________ Subscriber's Social Security #: ______________

Subscriber's Employer: ______________ Effective Policy Date: ______________

Please turn the page over and complete the back side.

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: ________________________

The Federal Government requires (HFM does NOT care) that we ask: race (i.e., white, black, asian, something else) ________________, hispanic? Y N ☐ I decline to answer. Your preferred language is: ________________ You need to answer this only ONCE.

PATIENT BD (mm/dd/yyyy): ________________

PATIENT Name (Last, First, MI): ________________________________

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Email: staff@HeritageFamilyMedicine.com

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. Further, I am responsible for payment whether or not the service rendered might have been covered by insurance or other payor if prior authorization had been obtained by HFM or myself and that HFM does not assume responsibility for seeking such authorization. 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. HFM does not bill auto insurance claims (even PIP patient's own insurance - they ALL fail timely payment) – patient pays at service.

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. Doing so raises the cost of care. "Co-pays" are due at time of service (if for any reason this amount is not collected, there will be an additional $15.00 processing fee added). It is impossible to know what amounts will be paid by insurance companies until they have completed their processing. All residual 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 $10.00 for each subsequent monthly statement. In the event it becomes necessary to initiate collection efforts, including but not limited to legal action (the venue for same being agreed to be within Thurston county, WA), I agree to pay the reasonable costs of collection, including but not limited to, agency fees, report fees and attorney's fees. A check returned for any reason (i.e. "not sufficient funds" or "account closed") will incur a fee of $40.00. HFM really does expect prompt payment.

HFM sees patients by appointment only - a valuable commodity that cannot be used by others when not kept or if significantly late. Such behavior results in higher costs and inconvenience to all other patients. A fee of $40.00 ($75.00 for OMT visits), payable before 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.

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