Bluegrass Pediatrics & Internal Medicine

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please Print) Today's Date: _____/_____/_____

Name: _____ **SS#:** _____/_____/_____

Billing Address: _____City: _____ State: ___ ZIP: _____

Street Address (if different from billing): _____

Home Phone: _____ Cell Phone: _____Email: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____

Employment Status: ❑ Employed ❑ Retired ❑ Self Employed ❑ Unemployed / ❑ Full Time ❑ Part Time

Occupation: _____ Student: ❑ Full Time ❑ Part Time

Employer: _____ Work Phone: _____

Employer Address: _____

PARENT/RESPONSIBLE PARTY (*if different from patient*)

Name: _____ **SS#: _____/_____/_____** DOB: _____/_____/_____

Address: _____ Relationship: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

INSURANCE INFORMATION/POLICY HOLDER: Do you have insurance? ❑ **Yes** ❑ **No**

Primary Insurance: _____ Subscriber ID #: _____

Group #: _____ ***Name of Cardholder***: _____

Date of Birth: _____/_____/_____ SS #: _____/_____/_____ Relationship: _____

Secondary Insurance: _____ Subscriber ID #: _____

Group #: _____ ***Name of Cardholder***: _____

Date of Birth: _____/_____/_____ SS #: _____/_____/_____ Relationship: _____

OTHER INFORMATION:

Referred by: _____ Primary Care Physician: _____

Pharmacy of choice: _____ Phone: _____

Do we have your permission to:

Leave a message on your answering machine at home? ❑ Yes ❑ No

In case of Emergency, whom should we notify? _____

Emergency Contact Address _____

Relationship to Patient: _____ Phone: _____

********** TURN OVER PAGE AND SIGN FORM PLEASE**********

104 Canewood Center Drive, Suite #2, Georgetown, KY 40324
(502) 863-2818

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ASSIGNMENT OF BENEFITS:

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to Bluegrass Pediatrics & Internal Medicine. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all of my medical records from other physicians and institutions in order that I may be given the appropriate care.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social Security Act and 31U.S.C.3801-3812 provides penalties for withholding this information.) We will file all claims as a courtesy to you and your insurance company(s) and all necessary documentation for claim processing.

PATIENT FINANCIAL RESPONSIBILITY:

If your insurance company has not paid your claim after 90 days, the full amount of the bill is your responsibility and payment is due immediately. Furthermore, I understand that, if for any reason, the account is turned over to a collection agency, I will be responsible for the collection fee of 35% and should non-payment of your account result in litigation, the collection fee shall increase to 50%, and I will also be responsible for court cost and service of summons cost.

_____ _____

Patient or Responsible Party Signature Date Signed

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