

Patient Registration

Name _____
First Middle Last

DOB _____ SS# _____ Email _____

Sex: MALE FEMALE Race: _____ Primary Contact Cell: _____ Secondary: _____

Mailing Address _____ Apt _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone Number _____

Primary Care Provider _____

Insurance or Self Pay

Primary Insurance _____ Subscribers Name _____

Subscriber/Member# _____ Group _____

Subscriber's Date of Birth _____ Relationship to Patient Self/Spouse/Parent/Other

Secondary Insurance _____ Subscribers Name _____

Subscriber/Member# _____ Group _____

Subscriber's Date of Birth _____ Relationship to Patient Self/Spouse/Parent/Other

Financial Policies of GHC

- Copays are due and collectable at check-in for patient visits
- Any outstanding account balances must be paid prior to patient being treated.
- Self-pay patients must pay at check-in
- I authorize GHC to file claims to my insurance and I authorize benefits to be paid directly to GHC on my behalf.
- At the time of service GHC will collect from you the estimated amount of patient responsibility based on your current insurance plan. Following your visit you will receive an EOB from your insurance company stating the amount paid by your insurer and the remaining balance owed by you if any. Patients are responsible for all services not covered by their insurance carrier. I understand I will be billed by GHC for any remaining balance. After 90 days all past due accounts will be turned over to collections with an additional \$30 collection fee.

Please check all that apply:

- You have permission to leave information on my answering machine regarding my medical care
- You have permission to speak to 1. _____ (Relationship) _____
2. _____ (Relationship) _____ concerning my medical care.

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Signature (or guardian signature if under 18)

Date