Patient Registration

Name _____
First Middle Last

Birth Date _____/_____/_____ **SS#**_____

Sex: MALE FEMALE **Race:** White Hispanic Black Other
Email:_____**(required) Cell:**_____

Mailing Address_____**Apt** _____

City_____ **State** _____ **Zip Code**_____

Emergency Contact_____ **Phone Number**_____

Permission for GHC to communicate with me by Text and or Email Yes No
Do you have a Primary Care Provider: Yes NO Name:_____

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

- Self-pay patients must pay at check-in
- Copays are due and collectable at check-in for patient visits
- Any outstanding account balances must be paid prior to patient being treated.
- 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. All past due accounts will be turned over to a collection agency and will incur additional fees.

Please check all that apply:
☐ 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.

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Patient Signature (or guardian signature if under 18) **Date**