**PATIENT REGISTRATION FORM**

**Patient’s Name (Last, First, MI):**

**Patient’s Home Phone Number:** **Alternate**

**E-Mail Address:**

**Address:**  **Apt. #**

**City:** **State:** **Zip:**

**Date of Birth:** **Age:** **Sex:** M F **SSN:**

**Ethnicity:** **Hispanic or Latino:** Yes or No **Language:**

**Marital Status:** [ ] Married [ ] Single [ ] Divorced [ ] Widowed

**Emergency Contact:** **Relationship to Patient:**

**Phone Number:**

**INSURANCE INFORMATION**

**Primary Insurance:** **Secondary Insurance:**

**Patient is Subscriber/Policy Holder:** Y N **Patient is Subscriber/Policy Holder:** Y N

**INSURED INFORMATION (IF OTHER THAN PATIENT)- We will request to scan your ID and insurance**

**Subscriber/Policy Holder:** **Relationship to Patient:**

**Address:**

**Date of Birth:** **SSN:**

**Financial Policy**

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place or the original. I hereby authorize Elite Care Family Practice Clinic to bill insurance on my behalf for the covered services rendered by the practitioner’s and assign payment from my insurance company to Elite Care Family Practice Clinic or to the party who accepts payments. I certify that the information I have reported regarding my insurance coverage is current and accurate.

I agree that I am financially responsible for all charges incurred whether they are covered by insurance or not. Self-pay patients must pay at time of service and any co-payments and deductibles must be paid at time of service. Upon response from my insurance company, I understand that all charges remaining are due and payable immediately. An interest fee of 2% per month (24% annually) may be charged to my account after 90 days. Accounts turned over to collection may be subject to a reasonable attorney/collection fee equal to 30% of the outstanding balance. I understand that a $25.00 NSF fee will be charged on all returned checks, and they will be subject to be turned over to the District Attorney for collection. I authorize the Providers of the Practice and its designees to provide treatment. I further authorize non-practice labs, radiology center, pathologist and radiologist who may interpret and/or report on diagnostic test to provide such treatment, if such tests are ordered by my Practice provider. I have read the Elite Care Family Practice Clinic’s financial policy and understand that I, the patient or patient’s representative, are responsible for payment of all charges for services rendered.

**Signature:** **Relationship to Pt if Pt is a minor** **Date:**

*If authorized representative, relationship to patient*