

TOWN CENTER FAMILY MEDICINE PATIENT REGISTRATION

PATIENT INFORMATION	
Name: _____ Date of Birth: ____/____/____ Age: ____ Sex ____	
SSN: _____	Home Phone: (____) _____
Cell Phone: (____) _____	E-Mail: _____
Address: _____ Nick Name: _____	
City: _____	State: _____ Zip Code: _____
Employer: _____	Work Phone :(____) _____
Employer Address: _____	Date of Employment: _____
Physician: _____ How did you find out about us? _____	
INSURANCE INFORMATION	
-PRIMARY INSURANCE INFORMATION	
Subscriber Name: _____ Policy #: _____ Group # _____	
Subscriber DOB: _____	Subscriber SSN: _____
EMERGENCY CONTACT INFORMATION	
Name: _____ Relation to Patient: _____	
Home Phone: (____) _____ Work Phone : (____) _____	
- SECONDARY INSURANCE INFORMATION	
Subscriber Name: _____ Policy #: _____ Group # _____	
Subscriber DOB: _____ Subscriber SSN: _____	
Relation to Patient: _____	
Subscriber Employer: _____ Insurance Co. Name: _____	

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to FFPC, PC, or any of its affiliates or agents, lenders, or any third party services acting for FFPC, PC, or any of its affiliates.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to FFPC and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I authorize FFPC to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician for services.

Signed _____ Date: _____

Town Center Family Medicine

BILLING AND PAYMENT AGREEMENT

Welcome to Town Center Family Medicine. We are happy that you have chosen us as your primary care medical office. Finances are always a sensitive subject to address, however, we believe that is important to address insurance and payment issues at the onset of our relationship so that there are not issues for either of us once we begin. In order to facilitate a beneficial experience for you, let us explain how a primary care medical office operates and provide some tips on how to utilize your insurance benefits to your maximum advantage.

- ☞ Most people chose a doctor who is approved by their insurance company. Therefore, all initial paperwork must be completed correctly in order for us to receive third party insurance payment and so that you do not incur any unnecessary costs.
- ☞ Your individual insurance company sets your copay. You may also have a deductible that has to be met before the insurance will begin to pay for services. You pay this directly to your doctor s office and then when the deductible, (if any) is met, the insurance will begin to pay. This varies from company to company, so it is to your advantage to check with your company s benefit coordinator before you come for your visit.
- ☞ Many companies require that you see a pre-selected primary care physician. Make sure you check with your insurance company to make sure the doctor you wish to see is on their list of approved physicians or the insurance company may refuse to pay for your visit.
- ☞ We cannot charge the insurance company for missed appointments; therefore it is our policy to charge \$25.00 for cancellations of less than 24 hours prior to a scheduled appointment. Remember that you have committed for that time and have blocked out a physician s time to others. There will also be a \$25.00 service charge for all returned checks.
- ☞ If you should change insurance companies let us know so that we check to see if your coverage is the same. Should you change insurances and not inform us, you may become individually liable for visits that could have otherwise been covered under your new insurance. It is important that you let us know whether more than one insurance company covers you, and if so which insurance is primary and secondary so that we can bill the primary company first or your secondary insurance will be null and void.
- ☞ We hope that this will clear up any questions you may have about the clerical end of your visit with us. Please feel free to ask any other questions you have.

By your signature it is understood and agreed that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside of the office to any agency for the collection of fees, you will be charged for the additional expenses.

Signature: _____

Date _____