

Patient Registration Form

Patient _____
(Use Legal Name) Last First Middle Preferred Name
Address _____
Street _____
City State Zip Code
SSN _____ Birthdate _____ Sex: M _____ F _____
Employer _____ Phone: Work _____ Home _____
Married _____ Single _____ Divorced _____

Responsible Party if other than Patient

Name _____
Last First Middle
Address _____
Street _____
City State Zip Code
SSN _____ Birthdate _____ Sex: M _____ F _____
Employer _____ Phone: Work _____ Home _____
Relationship to Patient _____

Insurance

Primary _____ Group # _____ I.D. # _____
Address _____
Subscriber _____ SSN# _____ Birthdate _____
Last First Middle
Secondary _____ Group # _____ I.D. # _____
Address _____
Subscriber _____ SSN# _____ Birthdate _____
Last First Middle

Emergency Contact Person _____ Phone: Home _____ Work _____

Authorization Information

The undersigned, as patient (or as parent or guardian of the patient), so hereby authorized the attending physician/practitioner to medically and/or surgically manage the treatment of the above named patient and to provide such surgical and/or medical treatment, which, in the physician/practitioners judgment, is deemed necessary for the benefit of the patient.

Signature _____ Date _____

**McKenzie Family Practice, P.C.
Financial Agreement**

As a courtesy to our patients we bill your insurance company for you. If our office has not received payment or a denial within 45 days of the date of service the charges will be made patient responsibility. It will be your responsibility to contact your insurance company in regards to payment. Please initial _____

The following paragraphs detail you're your financial responsibility with McKenzie Family Practice, P.C.:

1. **Financial Agreement:** I, the undersigned, agree, whether I sign as agent or as patient, that in consideration of the medical services rendered to the patient, I hereby individually obligate myself to pay the account to McKenzie Family Practice, P.C. Payment at the time of service is required on all new accounts unless alternative arrangements have been made with the Business Manager.

2. **Assignment of Insurance Benefits:** I, the undersigned, hereby authorize payment directly to McKenzie Family Practice, P.C., of the group or personal benefits or any other insurance benefits otherwise payable to me, for medical services rendered by the clinic.

3. **Patient Certification, Authorization to release Medical Information:** I, the undersigned, authorize McKenzie Family Practice, P.C. to release any medical information that may be necessary to request claim reimbursement from insurance companies to whom claims have been submitted, and to release credit information to appropriate information gathering agencies.

4. **Collection Fees:** I, the undersigned, agree that if payment on this account is not made in accordance with the above mentioned terms, I will pay reasonable attorney's fees and other costs incurred for collection.

I certify that I have read the foregoing, and I am the patient, or am duly authorized to execute the above agreement and accept its terms.

Responsible Party _____

Relationship to Patient _____

Date _____