



**PATIENT REGISTRATION FORM (PLEASE PRINT) 2010**

PATIENTS NAME \_\_\_\_\_ DATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

PARENT/SPOUSE NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**PRIMARY INSURANCE** (IF ON MEDICAID YOU MUST PRESENT CARD AT EACH VISIT)

NAME \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_ INSURANCE PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

POLICY HOLDER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**SECONDARY INSURANCE**

NAME \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_ INSURANCE PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

POLICY HOLDER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**(For services provided by Family Medical Specialties to myself and covered family members)

I, (Policy Holder) \_\_\_\_\_ hereby assign the Medical Benefits and/or Surgical Benefits, to include Major Medical Benefits to which I am entitled.

**EMERGENCY CONTACT**

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

**DO YOU HAVE AN ADVANCE DIRECTIVE(LIVING WILL)?** \_\_\_\_ YES \_\_\_\_ NO

**ALTERNATE CONTACT**(NOT LIVING WITH YOU)

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

**FINANCIAL POLICY**

I HAVE RECEIVED A COPY OF THE FAMILY MEDICAL SPECIALTIES FINANCIAL POLICY. THIS POLICY OUTLINES THE EXPECTED PAYMENT GUIDELINES FOR SERVICES RENDERED.

**AUTHORIZATION**

AUTHORIZATION FOR CONSENT OF TREATMENT, RELEASE OF MEDICAL INFORMATION AND INSURANCE ASSIGNMENT. I HEREBY AUTHORIZE FAMILY MEDICAL SPECIALTIES TO TREAT ME FOR MY MEDICAL PROBLEM. **(PLEASE READ BEFORE SIGNING)** THIS STATEMENT COVERS BOTH ADULT AND MINOR PATIENTS: I understand that with my signature I am giving FMS authorization to bill me for the charges for treatment and to release information to: Insurance Companies listed on my assignment of benefits, Attorney's with signed release forms, and Physicians involved in care accordance with the FMS physician caring for me and family members. I understand I am personally responsible for all charges at the providers regular fees weather or not those fees deemed "above reasonable and customary" by my insurance company. I also understand that coverage denial by my insurance company do not mean that the services were unnecessary, only that they are not "covered" by my insurance company. I agree to pay for services in full unless payment arrangements have been made within FMS Financial Policy guidelines. I understand my contract with my insurance company is to pay my copay at the time of service, as well FMS requires the same.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

## **IN CASE OF BILLING ERRORS**

The Federal Truth Lending Act requires prompt correction of billing mistakes.

1. If you wish to preserve your rights under this Act, you must do the following to correct any billing errors.
  - a. Do not write on your bill. On a separate sheet of paper write the following.
    - i. Your name and address
    - ii. A description of the error and explain why you believe it is in error. If you are just requesting More information, explain the item you are unsure about, ask for evidence of the charge.
    - iii. The dollar amount of the suspected error.
  - b. Send your billing error notice to the creditor as soon as you can, **early enough to reach the creditor within 60 days after the bill was mailed to you.**
2. The creditor must acknowledge all letters pointing out possible billing errors within 30 days of receipt of the letter unless dispute can be corrected within that 30-day period. Within 90 days of receiving your letter the creditor must correct the error or explain why they believe the charge is not in error. Once the creditor has explained the bill, the creditor is under no further obligation to you even though you still believe that there is an error.
3. After the creditor has been notified, neither the creditor or the attorney nor a collection agency may send you a collection letter or take further action with respect to the disputed amount until the dispute is rectified, however, statements may be sent and the disputed amount can be applied toward your credit limit. You cannot be threatened with damaging credit information or credit rating or sued for the amount of the dispute, nor can that amount be reported to a credit-reporting agency. **You are required to pay any amount not in the dispute.**
4. If it is determined that an error has occurred the creditor will remove any finance charges reflected for the amount. If no error occurred you would be required to pay finance charges related to the disputed amount and pay any missed payments as a result of the amount dispute. The creditor must send you written notification, unless you have agreed that there was no error of the balance of the account. If an error in billing is determined you will then be given the standard time to pay the balance of the account, which would normally be given for new charges (30 days) before any additional finance charges can be charged as a result of the disputed amount.
5. If the creditor's explanation of the amount is not satisfactory and you notify the creditor **in writing within 10 days** of their notice of explanation you may still refuse to pay the disputed amount. The creditor has the right at that time to continue any attempt to collect the full amount due including using outside resources such as an attorney and/or a collection agency.
6. If the creditor does not follow these rules, the creditor is not allowed to collect the first \$50.00 of the disputed amount including finance charges even if there was no error.
7. If you have a problem with property or service purchased with a credit card, you may have the right not to pay the remaining amount due if you first attempt to return the merchandise or give the merchant time to correct the dispute.

### **I (WE) AGREE AND UNDERSTAND:**

1. That each purchase I incur and consent to be charges to my account is to be recorded on a sales ticket or similar form as seller may use, and if accepted by the seller it is referable to this agreement.
2. A statement will be sent detailing all charges, payments and credits entered on my account during the month prior to the statement closing. A total amount owing will be noted at the time indicated as new or current charges.
3. I may pay the balance in full **within 30 days** of the closing date and there will be no finance charges. If payment in full is not made within 30 days of the closing date I will pay the amount due according to the payment schedule in effect at the time.
4. **Finance Charges** will be calculated each month on the amount of unpaid charges, referred to as previous or past due balance, after deducting payments or credits and before adding new purchases.
5. If monthly payments become past due I agree to pay the total amount owing upon demand and to pay reasonable collection cost, attorneys fee and court cost permitted by law,
6. I have retained a copy of this agreement and disclosures relating to the Equal Credit Opportunity Act and Fair Credit Billing Act.
7. I understand delivery of this disclosure statement does not indicate the account I (we) are applying for has been approved and that I (we) will be informed of this decision separately.

**FAMILY MEDICAL SPECIALTIES WILL ADD A 1.5% FINANCE CHARGE TO ANY BALANCE OVER 120 DAYS LATE**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_