

ADULT REGISTRATION (age 18 and older)

Today's Date: _____

DO YOU HAVE MEDICARE PART B INSURANCE? YES NO

If you answered YES, please DO NOT continue filling out this form -- see receptionist.

If you answered NO, please continue filling out this form.

PLEASE DO NOT ABBREVIATE ANY INFORMATION

<u>Patient Information</u>		DOB _____	SEX: M F
First Name: _____	MI: ____	Last Name: _____	Marital Status: MAR'D SING DIV OTH
Address: _____		SSN: _____	
City: _____		State: _____	ZIP: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
Employer Name (no abbreviations please): _____			
Primary Care Physician: _____			

<u>Referring Physician Information</u>
Complete Name of Physician Who Referred You to Us: _____
Phone Number of Referring Physician: _____

<u>Insurance Information</u>	
Insurance Name: _____	
Ins ID# (Policy #) _____	Group # _____

<u>Insurance Subscriber (if other than patient)</u>	DOB _____	SEX: M F	
First Name: _____	MI: ____	Last Name: _____	Marital Status: MAR'D SING DIV OTH
Address: _____		SSN: _____	
City: _____		State: _____	ZIP: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
Employer Name (no abbreviations please): _____		If Not Employed (circle one):	
Patient's Relationship to Subscriber: _____		RETIRED UNEMP HOME MAKER N/A	

<u>Emergency Contact</u>	
Emergency Contact's Name _____	
Phone #: _____	Emergency Contact's Relationship to Patient: _____

<u>Power of Attorney (POA) Information</u>
Does anyone have a legal Power of Attorney to make your medical decisions or financial decisions for you? YES NO
<i>If yes, we will need to have a copy of this form in your medical record. Please provide the following information:</i>
POA's Name: _____ POA Phone #1 _____ POA Phone #2 _____
Can your Power of Attorney legally make MEDICAL DECISIONS or FINANCIAL DECISIONS for you? (circle all that apply)

UPDATES: I verify that the information on this form is current and unchanged.

DATE/INITIALS:

Patient's Billing Agreement PLEASE READ CAREFULLY!

- 1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed and payment in full will be due immediately.
- 2) I hereby request and authorize Mountain View Medical Group physicians & personnel to deliver medical care to me.
- 3) If Mountain View Medical Group is contracted with my insurance company, I authorize assignment of payment directly to the doctor for services provided me. I understand that Mountain View Medical Group will file the claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of the date of service.
- 4) I understand that, under the terms of the contract of the insurance company, co-payments must be paid at every visit.
- 5) If I have insurance that Mountain View Medical Group is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Mountain View Medical Group will file a claim with my primary insurance company (except Tricare) as a courtesy, but that it is my responsibility to follow up with my insurance company to insure personal reimbursement by them.
- 6) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
- 7) I understand that medical records are the property of the physicians of Mountain View Medical Group; however, I am entitled to copies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for these copies.
- 8) I hereby authorize the release of my medical information to the insurance company concerning any illness and treatment.
- 9) I acknowledge that I can obtain a copy of the Mountain View Medical Group's Privacy Rights / HIPAA Information from the front desk upon my request.
- 10) I understand that a \$35.00 fee may be charged for all appointments missed or not canceled at least 24-hours in advance.
- 11) I understand that if my account becomes past due, Mountain View Medical Group will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees, and court costs.
- 12) I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that MVMG is not responsible for interpreting these benefits, or for how my insurance company(ies) process the claims. I further understand that MVMG cannot serve as an intermediary between my insurance company and myself in claims processing or claims disputes; that I must personally resolve these matters with my insurance company.

Patient/Guarantor Signature _____ Date _____

Communication Consent:

A. I DO CONSENT TO LEAVE DETAILED MESSAGES AND/OR DISCUSSION:

I give Mountain View Medical Group, P.C., and their staff permission to leave detailed phone messages on, or to discuss my medical care and/or my billing account with, the following: (please initial each one you consent to). This consent will remain in effect until rescinded in writing.

My home phone voice mail # _____	Medical Care _____	Billing Account _____
My cell phone voice mail # _____	Medical Care _____	Billing Account _____
My work phone voice mail # _____	Medical Care _____	Billing Account _____
My spouse (name) _____	Medical Care _____	Billing Account _____
Other (name) _____ phone # _____	Medical Care _____	Billing Account _____

Signature: _____ Date: _____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally, and I do not authorize MVMG to leave detailed messages or conduct discussions regarding my medical care and/or billing account with anyone other than myself.

Signature: _____ Date: _____

C. REVOCATION OF PRIOR CONSENT:

I wish to rescind the above authorizations.

Signature: _____ Date: _____