Adult Patient Registration Form (Please Print Clearly)

Name:_____ **Patient** ( ) **Guarantor** ( ) **Appt. Date**:_____
First Name M.I. Last Name

Date of Birth: ___ /___/____ **SSN**: ____-____-_____ **Sex**: Male / Female **Marital Status**: Married ( ) Single ( ) Divorced ( )Widowed ( )

Age: _____ Race: _____ E-Mail Address: _____

Home Address: _____ **City**_____ **State**_____ **Zip Code**_____

Mailing Address (only if different from above): _____

Home Telephone Number: _____ **Cell Phone Number**: _____

Referred By: _____ **Physician: _____**

Physician's Address and Phone Number:_____

Patient's Place of Employment

Patient's Employer: _____ Work Phone: _____

Work Address:_____ ____ **City: _____ State: _____ Zip:**_____

Person to contact in case of an Emergency

Name: _____ Relationship: _____ Phone: _____

Please READ the appointment information below, sign and date.

We confirm all scheduled appointments on the business day prior to your appointment date. If we do not reach you, we will leave a message and require you to call and confirm your appointment by 2:00 p.m. the day prior to your appointment. This is to remind you of your scheduled appointment date and time and to ensure that another patient can be seen if you are unable to keep your appointment. If your appointment is confirmed and you "No Show" there will be a $35.00 charge placed on your account. Thank you in advance for your time and courtesy.

Patient's Signature: _____ Date: _____

Please fill out Insurance information on Page 2….

Primary Insurance Carrier Information

If this section is not completed in full, your insurance will not be filed.

Primary Insurance Carrier: _____ Insurance Phone #: _____

Claim Form Mailing Address: _____

Policy Number (or I.D. #): _____ Group Number: _____

Policy Holder's Name (Employee): _____ Employer Policy: Yes ( ) No ( )

If Employer Policy, name of Employer: _____ Phone #: _____

Relationship to Patient: Self ( ) Spouse ( ) Parent ( ) Other ( ) If other, Who: _____

Policy Holder's Home Address: _____

Policy Holder's SS#: _____ Policy Holder's Date of Birth: _____

Secondary Insurance Carrier Information

Secondary Insurance Carrier: _____ Insurance Phone #: _____

Claim Form Mailing Address: _____

Policy Number (or I.D. #): _____ Group #: _____

Policy Holder's Name: _____ Employer Policy: Yes ( ) No ( )

Relationship to Patient: Self ( ) Spouse ( ) Parent ( ) Other ( ) If other, Who: _____

Policy Holder's Home Address: _____

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Our Billing Policy

In order to establish optimal relations with our patient's and avoid misunderstandings regarding our payment policies we have listed them here for you.

1. If you do not have insurance or have insurance we do not accept, you must pay your charges in full at time of service.
2. PPO Network Members are expected to pay their co-payment at time of service. If insurance has not paid your claim within 90 days we will bill the patient / guarantor for services rendered.
3. We accept cash, personal checks, MasterCard, Visa and Discover for your convenience.
4. If your insurance requires pre-certification / pre-authorization for treatment the patient / guarantor are responsible for contacting the insurance company to obtain this **prior** to treatment.
5. We are members of numerous insurance carriers and it is your responsibility to contact your insurance carrier to make sure we are a provider. This needs to be done prior to treatment. **Check with your carrier for insurance information and benefits.**
6. Your signature below indicates that you understand and accept this policy.
7. Your signature below also authorizes Dr. Martha Tarpay's office to release such medical information to your insurance carrier as necessary to process your insurance claims (if any).
8. You herein authorize payment of medical benefits to Martha Tarpay, M.D. when an assigned claim is filed.

Patient or Legal Guardian Signature: _____ **Date:** _____