

PATIENT REGISTRATION

Date and Time of First Appointment: _____

Name: _____ **Date of Birth:** _____

Address: _____ **City-St-Zip:** _____

Home Phone: _____ **Race:** _____ **Sex:** _____ **Marital Status:** _____ **Age:** _____

Work Phone: _____ **Employer:** _____ **Occupation:** _____

Work Address: _____ **City-St-Zip:** _____

Patient's Social Security Number: _____

Relation to Responsible Party: _____ **Social Security No.:** _____

Spouse or Guardian Name: _____ **Date of Birth:** _____

Spouse or Guardian Employer: _____ **Occupation:** _____

Work Address: _____ **City-St-Zip:** _____

In Case of Emergency, Notify: _____ **Relationship:** _____
Work Phone: _____ **Home Phone:** _____

Who referred you to us? _____ **Telephone No.** _____

Address: _____ **City-St-Zip:** _____

Name of Primary Care Physician: _____

Address: _____ **City-St-Zip:** _____

INSURANCE: Please give us your insurance ID cards for copying. We will return them to you. Please call the office prior to your appointment to verify that Carolina Arthritis Associates does accept your insurance.

PRIMARY Insurance Carrier: _____

Certificate No. _____ **Group No.** _____

Policyholder's Name: _____ **Social Security No.** _____

Date of Birth: _____ **Name of Employer:** _____

NAME: _____

SSN: _____

AUTHORIZATION OF BENEFITS:

I request that payment of authorized benefits be made on my behalf to Carolina Arthritis Associates, P.A., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

We want to be helpful in every way possible. We are happy to assist you with pre-certification and filing of claims. Pre-certification must be received prior to your office visit. However, your insurance policy remains a contract between you and your carrier, not CAA and your carrier. Final responsibility for payment for services rendered remains with the patient.

Patients who do not have insurance coverage are required to pay \$300 before being seen by a physician. Patients who do have insurance must pay their co-pay amounts at the time of the office visit.

We would like to inform our patients that Medicare has reduced its coverage for services. The Medicare patient will, therefore, be totally responsible for non-allowed charges which may include hemocults and frequently ordered tests and procedures.

I understand and agree to the above policies, including the policy regarding Medicare reimbursement.

Signature: _____

Date: _____