

REGISTRATION INFORMATION (please print)

PATIENT INFORMATION

Patient Full Name: _____ (Maiden Name _____) Age: _____ Sex: M or F Weight: _____ Race _____
Home Address _____ City _____ State _____ Zip Code _____
Birthdate: _____ Home Phone(s) # _____ Social Security # _____ Marital Status: M D S W
Spouse/Nearest Relative/Address and Contact Phone # _____
Family Physician _____ Referred By _____

GUARDIAN/Power of Attorney-Name/Contact Phone number: _____

Minors (patients under 18 years of age) MUST complete the following information:

Mother/Father/Guardian Name/Address: _____ Contact Phone# _____

PATIENT EMPLOYER INFORMATION

Employer's Name _____ Phone number _____
Employer's Address/City/State/Zip Code _____

PATIENT INSURANCE INFORMATION

Primary Insurance Company: _____ Insured ID _____ Group# _____
Secondary Insurance Company (if any): _____ Insured ID _____ Group# _____

INSURED PERSON(S) (IF NOT PATIENT)

Name of **Primary** Insured _____ Phone number _____ Insured Social Security# _____
Billing Address/City/State/Zip Code _____
Insured's Relationship to Patient: Spouse ___ Parent ___ Guardian ___ Other (please explain) _____ Insured Date of Birth _____
Name of **Secondary** Insured _____ Phone number _____ 2nd Insured.Social Sec.# _____
Billing Address/City/State/Zip Code _____
Insured's Relationship to Patient: Spouse ___ Parent ___ Guardian ___ Other (please explain) _____ 2nd Insured .Date of Birth _____

INSURED PERSON EMPLOYER INFORMATION (IF NOT PATIENT)

Primary Insured Employer Name _____ Phone number _____
Primary Insured Employer Address/City/State/Zip Code _____
Secondary Insured Employer Name _____ Phone number _____
Secondary Insured Employer Address/City/State/Zip Code _____

- I authorize use of this form on all my insurance submissions under current HIPAA guidelines.. Our office will bill only insurance presented at time of service.
- I authorize the release of pertinent information about myself to insurance carriers & The Healthcare Financing Administration and their agents any information needed to determine the benefits payable for related services.
- I understand that I am responsible for all usual and customary fees or fees as determined by Jetmore, Bawa and Hirons-PC.
- I understand I am responsible for services provided by our physician(s) and/or audiologist, even though, my insurance company may determine them to be not medically necessary, a non-covered service or an out of network service.
- I understand that I am responsible for obtaining a second opinion (if necessary), any pre-certifications and/or pre-utilizations and to consult with my insurance carrier regarding any benefits payable on my procedures/office visits.
- I permit a copy of the authorization to be used in place of the original in my medical records.
- I request the payment of authorized Medicare benefits and/or other insurance benefits made on my behalf to Jetmore, Bawa and Hirons-PC for any and all services furnished to me by the medical corporation.
- I authorize use of this form as consent for Jetmore, Bawa and Hirons-PC to obtain medical records from any physician or healthcare facility for which I have been treated by/at.
- I understand that there will be an additional fee of \$25.00 for any non-sufficient funds check presented to Jetmore, Bawa and Hirons -PC for payment upon my account.
- I hereby agree to pay Jetmore, Bawa and Hirons-PC the charges for all medical services rendered. I shall also be responsible for any collections fees equal to 35% of the delinquent balance and/or any attorney fees incurred.

PATIENT/GUARDIAN/POA SIGNATURE _____ DATE: _____

VERIFIED INFORMATION DATE (S): _____