

PATIENT REGISTRATION

(DOCTOR with whom you have an appointment) _____ Date: _____ Account # _____

1. Referring / Primary Doctor _____ 4. Emergency Room _____
Address _____ 5. Yellow Pages _____
(Must have) Phone # () _____ 6. Other (please specify) _____
2. Referral Agency (please provide name) _____

3. Friend _____

PATIENT INFORMATION

Name: _____ Phone: () _____
(Last) (First) (Middle)
Address: _____ Email: _____ Cell Ph.: () _____
City: _____ State: _____ Zip: _____ County: _____ Pager: () _____
Sex: _____ Age: _____ Date of Birth: _____ Social Security #: _____
Marital Status: _____ Do you have a living will or advance directive?: YES NO (If yes, please provide us with a copy.)
(Must have the above information)

EMPLOYMENT INFORMATION

Please Circle One: not employed, fulltime, parttime, self employed, active military or retired? RETIREMENT DATE _____
Employer's Name: _____ Phone: _____ ext or dept.: _____
Address: _____

RESPONSIBLE PARTY INFORMATION (If different from patient)

Name: _____ Phone: () _____
(Last) (First) (Middle)
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Sex: _____ Age: _____ Date of Birth: _____ Social Security #: _____
Marital Status: _____ Relationship to Patient: _____

RESPONSIBLE PARTY EMPLOYMENT INFORMATION

Please Circle One: not employed, fulltime, parttime, self employed, active military or retired? RETIREMENT DATE _____
Employer's Name: _____ Phone: _____ ext or dept.: _____
Address: _____

SPOUSE INFORMATION

Name: _____ Phone: () _____
(Last) (First) (Middle)
Address: _____
City: _____ State: _____ Zip: _____ County: _____
Sex: _____ Age: _____ Date of Birth: _____ Social Security #: _____
Marital Status: _____

SPOUSE EMPLOYMENT INFORMATION

Please Circle One: not employed, fulltime, parttime, self employed, active military or retired? RETIREMENT DATE _____
Employer's Name: _____ Phone: _____ ext or dept.: _____
Address: _____

FRIEND OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relationship: _____
Address: _____ Daytime Phone: () _____

INSURANCE INFORMATION

DO YOU HAVE MEDICARE? No Yes Medicare #: _____
DO YOU HAVE MEDICAID? No Yes Medicaid #: _____
PRIMARY INSURANCE COMPANY:
Insured Name: _____ Relationship to insured: _____
Birthdate: _____
Name of Insurance Company: _____ Phone: () _____
Address: _____

(Must have) Patient ID # _____ Group # _____
Is pre-certification required for services? Yes No Does your insurance require a specific lab or pathologist?
Is a referral number required for services? Yes No Yes No If yes, please specify:
Is policy a PPO (Preferred Provider Organization)? Yes No _____
Is policy a HMO (Health Maintenance Organization)? Yes No _____

PATIENT NAME: _____ Account #: _____

**INSURANCE
INFORMATION
CONTINUED**

SECONDARY INSURANCE COMPANY:

Insured: Name: _____ Relationship to Insured: _____

Birthdate: _____

Name of Insurance Company: _____ Phone: (____) _____

Address: _____

Patient ID #: _____ Group #: _____

Is pre-certification required for services? Yes No

Is a referral number required for services? Yes No

Is policy a PPO (Preferred Provider Organization)? Yes No

Is policy a HMO (Health Maintenance Organization)? Yes No

OTHER INSURANCE COMPANY:

Insured: Name: _____ Relationship to Insured: _____

Birthdate: _____

Name of Insurance Company: _____ Phone: (____) _____

Address: _____

Patient ID #: _____ Group #: _____

Is pre-certification required for services? Yes No

Is a referral number required for services? Yes No

Is policy a PPO (Preferred Provider Organization)? Yes No

Is policy a HMO (Health Maintenance Organization)? Yes No

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of medical benefits to the physician and/or Facility in the event they file for the insurance.

Patient's or Authorized Individual's Signature Date _____

I have been provided a copy of my doctor's practice brochure which list his credentials as well as practice information.

Patient's or Authorized Individual's Signature Date _____

MEDICARE PATIENTS

Patient Name: _____ Medicare #: _____

Medicare will only pay for certain services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for it.

Medicare is likely to deny payment for the following services:

1. Procedure Code: A9150 Description: Procedure prep kit
Reason: Medicare lists prep kits as a "supply item". These kits are, in fact, a medical necessity item for the procedures performed by your physician.
2. Procedure Code: 990000 Description: lab handling fees
Procedure Code: 36415 Description venipuncture
Reason: Medicare does not allow physicians' offices to bill for lab work, handling and/or for the shipping to the laboratory for processing. The venipuncture fee and the handling fee are legitimate expenses incurred by the physician's office to insure that your lab work is drawn properly, and received promptly by the laboratory. Medicare will be billed separately by the laboratory for the performance of your lab tests.
3. Procedure Code: 45378 Description: Colonoscopy for health screen only (not indicated high risk). One (1) allowed per ten (10) years.

I agree that I have been notified by my physician the he/she believes that in my case Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient's or Authorized Individual's Signature Date _____