North Stonington Medical Walk In Center, PC

Patient Registration

Patients First Name:_____ MI____Last Name:_____

Street Address:_____ City:_____

State:_____ Zip Code:_____

Date of Birth:_____ Age:_____ Sex:___Female ___ Male

Cell Phone:_____ Home Phone:_____

Employer:_____ Occupation:_____

Work Phone:_____ Email:_____

Guardian Information if Patient is under 17:
Name:_____Relationship:_____

Date of Birth:_____Full Address:_____

Patient Ethnicity:_____ Hispanic or Latino _____ Non Hispanic or Latino

Race:___ American Indian or Alaska Native ___ Asian___ Black or African American___ Native Hawaiian or Other Pacific Islander ___White

Primary Insurance Information:

Insurance Company Name:_____

Policy Number:_____ Group Number:_____

Policy Holder Name:_____Date of Birth:_____

Relationship to Insured:_____Self _____Spouse _____Dependent

Insurance Company Claim Address:_____

Secondary Insurance Information:

Insurance Company Name:_____

Policy Number:_____ Group Number:_____

Policy Holder Name:_____Date of Birth:_____

Relationship to Insured:_____Self _____Spouse _____Dependent

Insurance Company Claim Address:_____

Emergency Contact:

Name:_____ Relationship:_____

Street Address:_____City:_____

State:_____ Zip Code:_____ Best Phone:_____

Patient Responsibility - Insurance Disclaimer

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary.". If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. Under this arrangement, you are responsible for paying your copay, any non-covered portions or procedures, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. Medicare, Medicaid, HMOs, private insurance, and any other healthcare plans to North Stonington Medical Walk In Center, PC.

Consent for Medical Treatment: I authorize North Stonington Medical Walk In Center, PC and their employees to render medical treatment and evaluation for this visit and all future appointments. I will rescind this agreement in writing if I choose to nullify.

Release of Information: I authorize the release of information necessary to determine the liability of payment and to obtain reimbursement of any claim. This may include any or all parts of my medical records to my insurance company or companies, or Workers Comp claims. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release the benefits payable to which I am entitled, including,

_____ _____

Patient and our Guardian Signature **Date**