

Anderson Clinic Registration Form

Today's Date: _____

SSN: _____ Patient Name: _____ Sex: M or F

D.O.B. _____ Email Address _____ Marital Status S ___ M ___ D ___ W ___

Address: _____ City: _____ State: _____ Zip: _____

Employed: Y ___ N ___ Retired ___

Home Phone: _____ Work Phone: _____ Cell Phone () _____ - _____

Employer: _____ Provider: _____

Reason for visit: _____

Date of onset of symptoms: _____

Referring Physician Information

Were you referred by a physician: Y ___ N ___ If so, provider's full name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone () _____ - _____

Primary Insurance Information

Please provide your insurance card to the receptionist

Insurance Company: _____ Phone number: () _____ - _____

Policy #: _____ Group #: _____ Other #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured/Card Holder's Name: _____ Relationship: _____ Policy Holder's D.O.B. _____

Secondary Insurance Information

Please provide your insurance card to the receptionist

Insurance Company: _____ Phone number: () _____ - _____

Policy #: _____ Group #: _____ Other #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured/Card Holder's Name: _____ Relationship: _____ Policy Holder's D.O.B. _____

Workers' Compensation Information

Insurance/Carrier Name: _____ Phone #: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Fax #: _____ Claim #: _____ DOI: _____

Case Manager/Adjuster: _____ Phone #: () _____ - _____

Emergency Contact

Name: _____ Relationship: _____

Contact #: () _____ - _____ Other contact #: () _____ - _____

Guarantor/Responsible Party

Person responsible for bill: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN _____ - _____ - _____ Sex: ___ Work Phone () _____ - _____ Home Phone () _____ - _____

Pharmacy Information

Pharmacy Name _____ Phone _____ Address _____

AUTHORIZATION TO PAY BENEFITS AND RELEASE MEDICAL INFORMATION TO THE ANDERSON CLINIC, INC.

I, _____, hereby authorize the Anderson Clinic, Inc. to apply for benefits for covered services rendered and request payments for Medicare, BC/BS of the National Capital Area, Medigap and/or _____ to be made directly to the Anderson Clinic, Inc.

I certify the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, BC/BS of the National Capital Area, Medigap, or in the case of Medicare Part B benefits to the Social Security administration and Health Care Finance Administration or Trailblazers Medicare.

Workers Comp cases will be billed to their respective Workers Comp carrier, however, if denied, the patient becomes responsible for payment.

I further understand that I am responsible for all outstanding balances, fees and finance charges for the patient regardless of insurance coverage. If the account is placed with a collection agency or attorney, the undersigned agrees to pay 25% in addition to the outstanding unpaid balance as a reasonable collection fee, together with additional cost/ expenses of collections to the present extent of the law.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me, in writing, at any time.

I hereby state that I have read and fully understand the above.

Signature

Print Name

Date

FILL OUT BELOW ONLY IF YOU HAVE MEDICARE:

Please update my records to reflect the following information:

Are you currently employed?	YES	NO
If yes, are there more than 20 employees in your company?	YES	NO
If retired, effective date of retirement. Month _____ Day _____ Year _____		
Is your spouse currently employed?	YES	NO
If yes, are there more than 20 employees in the company?	YES	NO
If retired, effective date of spouses retirement. Month _____ Day _____ Year _____		
Are you or your spouse covered under any other insurance plan through a current employer?	YES	NO
If retired, were you or your spouse covered under any other insurance plan while employed?	YES	NO

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____