PATIENT REGISTRATION

(PLEASE PRINT)

MRN #_____

1. PATIENT INFORMATION

PATIENT'S LEGAL NAME: _____

DATE OF BIRTH: _____ SEX: ☐ M ☐ F

RACE: White ☐ African American ☐ Asian ☐ American Indian ☐ Native Hawaiian ☐ All Other ☐

ETHNICITY: Hispanic ☐ All Other ☐

SOCIAL SECURITY #_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

E-MAIL ADDRESS _____

ADDRESS _____

CITY _____ STATE_____ZIP _____

ARE YOU A STUDENT? YES ☐ NO ☐

ARE YOU RETIRED? YES ☐ NO ☐ IF YES, RETIREMENT DATE:_____

ARE YOU DISABLED? YES ☐ NO ☐ IF YES, DISABILITY DATE: _____

EMPLOYER NAME_____
(If you are retired or disabled, please complete the above line for your former employer)

SPOUSE Name _____

Employer _____

EMERGENCY CONTACT, OTHER THAN SPOUSE Name of Person_____

Relationship to Patient _____ Phone _____

2. PERSON RESPONSIBLE FOR THE BILL AFTER INSURANCE PAYS

IS THE GUARANTOR OF THE ACCOUNT THE SAME AS THE PATIENT YES ☐ NO ☐
(If you checked YES, you do not need to complete this section)

GUARANTOR NAME _____

RELATIONSHIP TO PATIENT _____ _____

SOCIAL SECURITY #_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

GUARANTOR'S EMPLOYER NAME_____

(Is the Guarantor's address the same as the Patient's address above? YES ☐ NO ☐ If YES, please do not complete the below)
ADDRESS _____

CITY _____ STATE_____ZIP _____

3. PARENT / LEGAL GUARDIAN INFORMATION

PLEASE COMPLETE THE BELOW INFORMATION IF YOU ARE THE PARENT OR LEGAL GUARDIAN ACCOMPANYING THE PATIENT LISTED IN SECTION (1) ABOVE AND YOU ARE NOT THE GUARANTOR LISTED IN SECTION (2).

PARENT OR LEGAL GUARDIAN NAME _____

SOCIAL SECURITY #_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

PARENT / LEGAL GUARDIAN EMPLOYER NAME_____

(Is the parent's / guardian's address the same as the Patient's address above? YES ☐ NO ☐ If YES, please do not complete the below**)**
ADDRESS _____

CITY _____ STATE_____ZIP _____

4. ASSIGNMENT OF BENEFITS & PAYMENT POLICY

ASSIGNMENT OF BENEFITS - I assign to Hattiesburg Clinic all insurance benefits and settlements, whether medical or liability insurance, for the full amount of the total medical care charges. I also assign the proceeds of any judgment or settlement of any claim with any third party, or other amounts determined to payable in connection with treatment provided at Hattiesburg Clinic. I authorize payment of all benefits and settlements to be paid directly to Hattiesburg Clinic for services rendered. This authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

MEDICAL RECORD & RELEASE OF INFORMATION - I authorize the release of all medical information necessary to process medical claims and permit the following to be used in place of this original document: (1) a photocopy of other facsimile reproduction of this authorization, or (2) use of a computer to indicate that my signature is on file at Hattiesburg Clinic. By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

PAYMENT POLICIES - As a courtesy to its patients, Hattiesburg Clinic assists in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that Hattiesburg Clinic is a participant under my policy. Further, I understand that my insurance company may not cover fully (or at all) cover my bills for services provided, and that I will be responsible for the payment of any remaining balance due. I understand that all co-payments and deductibles are payable at the time of service.

I understand that it is my responsibility to provide Hattiesburg Clinic with appropriate and current insurance information – and to notify Hattiesburg Clinic immediately upon any change in my insurance coverage – to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims related to services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that a single account will be created for patients in my same family, such as husband, wife and children. Hattiesburg Clinic prepares statements on patient accounts on a monthly cycle. I understand that all charges to my account with the Clinic are due and payable within the month following the date of the statement on which the charges first appear. I understand that I will be responsible for paying, on behalf of myself, my spouse, and/or my children, co-payments, deductibles, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies). I understand that an 8% per month interest fee may be added to my balances which are over 90 days past due.

In the event of failure to pay for medical services rendered to me, my spouse and/or my children, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by Hattiesburg Clinic. I understand that I will be responsible for all attorney fees plus all costs associated with the collection process, such as court costs and any fees assessed by the collections agency, and that these fees and costs will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further, I understand that my medical information will necessarily be revealed in these efforts to collect payment of monies owed.

PRINT NAME _____

SIGNATURE _____ DATE _____