MOUNTAIN VIEW MEDICAL GROUP **2010**

PARTNERS IN WOMEN'S HEALTH

ADULT REGISTRATION (age 18 and older)

Today's Date: _______________

DO YOU HAVE MEDICARE PART B INSURANCE? YES NO

If you answered YES, please DO NOT continue filling out this form -- see receptionist.
If you answered NO, please continue filling out this form.

PLEASE DO NOT ABBREVIATE ANY INFORMATION

Patient Information

DOB _____________ SEX: M F

First Name:______________ MI: ___ Last Name: ____________________

Marital Status: MAR'D SING DIV OTH

Address: ____

SSN: _______________________

City: ____

State:_____ ZIP:____________

Home Phone: __________________ Work Phone: ____________________

Cell Phone: ________________

Employer Name (no abbreviations please): ____________________________________

Primary Care Physician: ______________________________

Referring Physician Information

Complete Name of Physician Who Referred You to Us: ____

Phone Number of Referring Physician: ___________________

Insurance Information

Insurance Name: ____

Ins ID# (Policy #) __________________________________ Group # __________________________________

Insurance Subscriber (if other than patient)

DOB _____________ SEX: M F

First Name:______________ MI: ___ Last Name: ____________________

Marital Status: MAR'D SING DIV OTH

Address: ____

SSN: _______________________

City: ____

State:_____ ZIP:____________

Home Phone: __________________ Work Phone: ____________________

Cell Phone: ________________

Employer Name (no abbreviations please): ____________________________________

If Not Employed (circle one):

RETIRED UNEMP HOMEMAKER N/A

Patient's Relationship to Subscriber: ________________________________

Emergency Contact

Emergency Contact's Name ____

Phone #: _______________________ Emergency Contact's Relationship to Patient: ____________________

Power of Attorney (POA) Information

Does anyone have a legal Power of Attorney to make your medical decisions or financial decisions for you? YES NO

If yes, we will need to have a copy of this form in your medical record. Please provide the following information:

POA's Name: ________________________ POA Phone #1 ______________ POA Phone #2 ______________

Can your Power of Attorney legally make **MEDICAL DECISIONS** or **FINANCIAL DECISIONS** for you? (circle all that apply)

How do you wish to be addressed? _____________________

Religion: ___________________

Spouse's Name: __________________________

Pharmacy Name & Location: ____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Physician (name?): ____________ Hospital? ____________ Insurance Company? __________________

Advertisement (where)? ______________________________

Patient's Billing Agreement   PLEASE READ CAREFULLY!

1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed and payment in full will be due immediately.
2) I hereby request and authorize Mountain View Medical Group physicians & personnel to deliver medical care to me.
3) If Mountain View Medical Group is contracted with my insurance company, I authorize assignment of payment directly to the doctor for services provided me. I understand that Mountain View Medical Group will file the claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of the date of service.
4) I understand that, under the terms of the contract of the insurance company, co-payments must be paid at every visit.
5) If I have insurance that Mountain View Medical Group is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Mountain View Medical Group will file a claim with my primary insurance company (except Tricare) as a courtesy, but that it is my responsibility to follow up with my insurance company to insure personal reimbursement by them.
6) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
7) I understand that medical records are the property of the physicians of Mountain View Medical Group; however, I am entitled to copies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for these copies.
8) I hereby authorize the release of my medical information to the insurance company concerning any illness and treatment.
9) I acknowledge that I can obtain a copy of the Mountain View Medical Group's Privacy Rights / HIPAA Information from the front desk upon my request.
10) I understand that a $35.00 fee may be charged for all appointments missed or not canceled at least 24-hours in advance.
11) I understand that if my account becomes past due, Mountain View Medical Group will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees, and court costs.
12) I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that MVMG is not responsible for interpreting these benefits, or for how my insurance company(ies) process the claims. I further understand that MVMG cannot serve as an intermediary between my insurance company and myself in claims processing or claims disputes; that I must personally resolve these matters with my insurance company.

Patient/Guarantor Signature ____________________________ Date ________________

Communication Consent:

A. I DO CONSENT TO LEAVE DETAILED MESSAGES AND/OR DISCUSSION:

I give Mountain View Medical Group, P.C., and their staff permission to leave detailed phone messages on, or to discuss my medical care and/or my billing account with, the following: (please initial each one you consent to). This consent will remain in effect until rescinded in writing.

My home phone voice mail # _________________________ Medical Care ______ Billing Account ______

My cell phone voice mail # ___________________________ Medical Care ______ Billing Account ______

My work phone voice mail # __________________________ Medical Care ______ Billing Account ______

My spouse (name)_________________________________ Medical Care ______ Billing Account ______

Other (name)___________________ phone # ___________ Medical Care ______ Billing Account ______

Signature: ____ Date: _____________

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I wish to be contacted personally, and I do not authorize MVMG to leave detailed messages or conduct discussions regarding my medical care and/or billing account with anyone other than myself.

Signature: ____ Date: ___________________

C. REVOCATION OF PRIOR CONSENT:

I wish to rescind the above authorizations.

Signature: ____ Date: ___________________

UPDATES: I verify that the information on this form is current and unchanged.

DATE/INITIALS:

_________ _________ _________ _________ _________ _________ _________ _________

_________ _________ _________ _________ _________ _________ _________ _________