J Robin Atwell MD, PA
PATIENT REGISTRATION FORM

Name:_____DOB _____-_____-_____

SSN#: _____-_____-_____ Home # _____-_____-_____ Cell# _____-_____-_____

Address:_____

City: _____ State:_____Zip: _____

Patients Employer:_____Work# _____-_____-_____Ext: _____

Email: **(Please print legibly)** _____

Gender: F or M Race: _____Marital Status: _____

Spouse Name: _____Phone Number: _____

Referring Doctor: _____Primary Care Doctor: _____

Emergency Contact: _____Number: _____-_____-_____

Pharmacy Name: _____Number: _____-_____-_____

Do we have permission to leave messages concerning your appointments and care on your answering machine? **Yes/No**

PRIMARY Insurance Company Name: _____

Subscriber's Name: _____Date of Birth: _____

SECONDARY Insurance Company Name: _____

Subscriber's Name: _____Date of Birth: _____

Per HIPAA regulations, I hereby authorize J Robin Atwell MD, PA and its employees to discuss my health, financial and/or insurance information with myself and with:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

FINANCIAL/BILLING POLICY/PRIVACY PRACTICE NOTICE

Authorization for Payment and Financial Responsibility

I agree to provide my **insurance card** at each visit, pay my co-pay/deductible &/or co-insurance and understand that fees for services should be paid at check-in or before surgery and are my financial responsibility. If your insurance company requires you to use a specific lab, please notify us as there are times that we will send specimens out to be tested. I understand that claims not paid by my insurance company within 30 days from the date of service may be transferred to patient responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "noncovered services" or "not medically necessary" are also my financial responsibility. I understand that if my account is transferred to an outside collection agency that I agree to pay all associated cost including but not limited to any collection fees assessed, applicable attorney fees and court costs. Furthermore, I understand that after my account balance is transferred to a collection agency I agree to pay for any future services when seen regardless of insurance. J Robin Atwell MD, PA charges **$25.00** for a returned check and future services must be paid for with cash, money order or cashier's check. **We require a 24 hour cancellation notice to avoid any charges.** We reserve the right to charge **$25.00 for no-show** appointments without a 24 hour cancellation notice. **We charge $25.00 for the completion of FMLA, disability and life insurance application forms, prior authorizations for medications if required by your insurance company & letters to insurance companies.**

Authorization to Release Medical Information and Consent to Treatment

I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, and/or the United Postal Service including the diagnosis, treatment or examination rendered to me during the period **of treatment for the processing of insurance claims, or to satisfy any requirements of managed care organizations of** which I am a member. I assign to the physician or physician's group all payment for the medical services rendered to me. I authorize the use of an automated appointment reminder phone/answering system messaging system. I also authorize J Robin Atwell MD, PA to utilize any e-mail address that I provide to them as a form of communication. I understand that if I request any change in this information that I am responsible for notifying this office in writing of such request. **I consent to treatment by the physicians of J Robin Atwell MD, PA. These policies supersede and replace any prior polices verbal or published policies.**

I acknowledge that J Robin Atwell MD, PAs' Notice of Privacy Practices will be made available to me upon request. This notice describes how this office may use and disclose my protected health information.

Thank you for choosing, J Robin Atwell MD, PA as your healthcare provider. We are committed to providing excellent healthcare services to you. As a part of our professional relationship, it is important that you have an understanding of our office policies. All patients must read and sign this form prior to receiving services.

_____ _____

Patient Name (please print) **Patient or Representative SIGNATURE**

Date of Birth: _____ **Today's Date:** _____