

PATIENT REGISTRATION



If you have not provided your insurance card, please complete the insurance section on the back of this form

PATIENT NAME		Last	First	Middle
PERMANENT ADDRESS		Street	Apt. No. City	Zip Code
TEMPORARY		Street	City	Zip Code
SOCIAL SECURITY NO.		PHONE (Area Code)		ALTERNATE PHONE (Area Code)
AGE	SEX	DATE OF BIRTH		BIRTHPLACE
PLEASE CIRCLE ONE: <small>If patient's age is less than 18 years, complete Side 2</small>				
Married	Single	Child	Divorced	Widowed
EMPLOYER			EMPLOYER'S PHONE NO.	
SPOUSE'S NAME (Parent, if child)		SPOUSE'S EMPLOYER (Parent for child)		SPOUSE'S SOCIAL SECURITY NO. (Parent for child)
<i>Services are provided to our patients, not their insurance companies. Payment is due when the service is provided regardless of whether you submit your claim to your insurance company. Other arrangements must be made with our Patient Financial Services Office.</i>				
PRIMARY CARE PHYSICIAN			PRIMARY CARE PHONE NO.	
OTHER-- FOR CHILD OVER 18 -- Are you a full time student? Yes No If yes, contact Insurance Co.				
Name of person (not living with you) to notify if unable to reach you:			PHONE NO.	NEXT OF KIN

IF VISIT IS FOR INJURY, BE SURE TO INFORM SECRETARY TODAY: DATE OF WORK INJURY: / /

AGREEMENT

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: For services beginning today, I authorize my holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of **MIMA** any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

FOR MEDIGAP INSURED'S AUTHORIZATION: I request that payment for authorized Medigap Benefits be made on my behalf to **MIMA** for any services furnished me by **MIMA**. I authorize the holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically. (**MIMA** must have accurate Medigap information on your fee ticket - please examine the information closely at each visit.)

INSURANCE AUTHORIZATION: I assign the benefits payable for physician services to the **MIMA** physician and organization furnishing the services and authorize **MIMA** to submit a claim to my health insurance carrier as needed for payment to the physician or me. I authorize any holder of medical or other information about me to release to my insurance carrier any information needed for this or a related claim. A photostatic copy of this authorization may be used in lieu of the original. This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

NOTICE OF HEALTH CARE INFORMATION: All patient records remain the property of **MIMA, PA**. Records are centralized and may be accessed by any **MIMA** medical provider, or **MIMA** employee, as a necessary function of their role within our organization. **MIMA** does not release Patient Records unless necessary for payment, treatment or operations, or if you have signed a request to transfer your Medical Record. We respect the right of patient confidentiality.

MIMA complies with all HIPAA and other federal privacy regulations. A notice of **MIMA** privacy policies is available upon request. I acknowledge, by signature below, that I have been made aware of my right to review or obtain a copy of the policies.

I have been advised payment is due on the day of service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains my responsibility for final payment on my account, regardless of the payment, or lack of payment, by my insurance carrier. I accept arrangements while continuing to receive care and services from Melbourne Internal Medicine Associates (**MIMA**).

PATIENT'S SIGNATURE (Required) _____ Date _____
I agree to the above.

SPOUSE'S SIGNATURE (Required) _____ Date _____
 Parent Trustee Guardian if Patient is a Minor I agree to pay if patient doesn't pay.

PATIENT REGISTRATION - Continued

MEDICAL INSURANCE INFORMATION

PRIMARY INS. CO.	POLICY NO.	GROUP NO.
ADDRESS OF INS. CO.		EFFECTIVE DATE
SUBSCRIBER NAME	SUBSCRIBER SOCIAL SECURITY NO.	SUBSCRIBER DATE OF BIRTH
SECONDARY INS. CO.	POLICY NO.	GROUP NO.
ADDRESS OF INS. CO.		EFFECTIVE DATE
SUBSCRIBER NAME	SUBSCRIBER SOCIAL SECURITY NO.	SUBSCRIBER DATE OF BIRTH
PARENT WITH CHILD TODAY	OTHER PARENT IN PATIENT'S HOUSEHOLD (STEP PARENT, ETC.)	OTHER PARENT WITH JOINT CUSTODY OR OTHER CUSTODIAL RIGHTS/RESPONSIBILITIES FOR CHILD
NAME:		
ADDRESS IF DIFFERENT THAN CHILD:		
EMPLOYER NAME:		
EMPLOYER PHONE:		
SOCIAL SECURITY NO.:		
BIRTH DATE OF PARENT FOR INSURANCE PURPOSES / /	/ /	/ /
DOES THIS PARENT COVER CHILD WITH MEDICAL INSURANCE? YES NO	YES NO	YES NO
NAME OF INSURANCE COMPANY:		
CLAIMS ADDRESS:		
GROUP NO.:		
POLICY NO.:		