



379 Stanaford Road
Beckley, WV 25801

201 Jones Avenue
Oak Hill, WV 25901

207 West Maple Avenue
Fayetteville, WV 25840

502 Main Street West
Oak Hill, WV 25901

Welcome To Our Office!

PATIENT INFORMATION

The person seeing the doctor.

GUARANTOR

Person responsible for all unpaid balances on this account.

INSURANCE

List all insurance for which you have a current card. List Medicare or Medicaid first.

EMERGENCY CONTACT

Spouse, step-parent significant other.

TODAY'S DATE		NEW PATIENT REGISTRATION	
PATIENT NUMBER		PLEASE COMPLETE ALL WHITE AREAS	
LAST NAME		FIRST NAME	MI
ADDRESS MAILING			
ADDRESS PHYSICAL			
CITY		STATE	ZIP
HOME PHONE		CELL PHONE	ALT NUMBER
SEX	M	F	MARITAL STATUS (M/S/D/W/SEP)
DATE OF BIRTH		PATIENT'S S.S. NO.	
DR. REQUESTING YOUR APPOINTMENT		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW <input type="checkbox"/> PATIENT <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> PROVIDER BOOK <input type="checkbox"/> OTHER	
PATIENTS EMPLOYER			
EMPLOYER ADDRESS			
CITY		STATE	ZIP
EMPLOYER PHONE		EXT.	
RESP. PARTY LAST NAME		FIRST NAME & INITIAL	RELATIONSHIP
ADDRESS			
CITY		STATE	ZIP
HOME PHONE		CELL PHONE	
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.	
RESP. PARTY EMPLOYER		EMPLOYER PHONE	EXT.
EMPLOYER ADDRESS		EMPLOYER FAX	
INSURANCE #1 NAME		INS. #1 CODE	
INSURANCE #1 ADDRESS		INS. #1 PHONE	
POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP
DATE OF BIRTH		SEX	M
CERTIFICATE #		GROUP NO.	MEMBER NO.
INSURANCE #2 NAME		INS. #2 CODE	
INSURANCE #2 ADDRESS		INS. #2 PHONE	
POLICY HOLDER LAST NAME		FIRST NAME	RELATIONSHIP
DATE OF BIRTH		SEX	M
CERTIFICATE #		GROUP NO.	MEMBER NO.
Were you injured on the job?		Y	N
Date of Injury:		Claim #:	
WC Carrier:		Were you injured in a motor vehicle accident?	
		Y	
		N	
NAME		RELATIONSHIP	
DATE OF BIRTH		S.S. NO.	
EMPLOYER		WORK PHONE	
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		RELATIVE/FRIEND PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health, and well being. I acknowledge that no representatives, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient. I understand that I am responsible for paying 100% of co-pays and deductibles to be paid at the time of service.

INITIAL _____

NOTE TO DIVORCED PARENTS: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent.

INITIAL _____

PLEASE NOTE: We do not accept auto insurance or bill for motor vehicle accidents.

INITIAL _____

RETURNED CHECK FEE:

For any check that is returned due to non-sufficient funds, it is our policy to charge a fee of \$25.00.

INITIAL _____

ADVANCED DIRECTIVE

- 1. Do you have a living will? Yes ___ No ___
- 2. Have you appointed a Health Care Representative? Yes ___ No ___
- 3. Have you given anyone your Power of Attorney Yes ___ No ___
- 4. Resuscitate? Yes ___ No ___

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received the Notice of Privacy Practices. (If patient did not sign, give reason and initial.)

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail

I give consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care information about me or for me on my answering machine or voice mail via the telephone number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

NUMBER (_____) _____

INITIAL _____

Who May We Leave Test Results With If Unable To Contact Patient or Parent?

Name _____ Relationship _____ Phone _____

Patient's Signature: _____

Date: _____

Parent/Guardian: _____

Date: _____

PLEASE BE SURE THE RECEPTIONIST OBTAINS A COPY OF YOUR DRIVER'S LICENSE/PHOTO ID AND INSURANCE CARD(S) — THANK YOU