Kelly Rich

Family Medicine

PRE-REGISTRATION INFORMATION

For Office Use Only

Appointment Date/Time:
Provider:

PATIENT INFORMATION (please print):

PATIENT NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY No.	DATE OF BIRTH	SEX
MAIDEN NAME	LAST	FIRST	MIDDLE	EMPLOYER		MARITAL STATUS
STREET		APT		OCCUPATION (INDICATE IF STUDENT)		
CITY		STATE	ZIP	STREET	CITY / STATE / ZIP	
HOME PHONE: ( )	BUSINESS / DAYTIME PHONE: ( )	EXT		CELL PHONE: ( )	DRIVER'S LICENSE #	

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION):

PATIENT	LAST	FIRST	MIDDLE	RELATIONSHIP	SOCIAL SECURITY NUMBER	D.O.B.
STREET		APT		EMPLOYER	OCCUPATION	
CIITY	STATE	ZIP		STREET		
HOME PHONE: ( )	BUSINESS PHONE: ( )			CITY	STATE	ZIP

EMERGENCY CONTACT – IF RESIDING AT A DIFFERENT ADDRESS (e.g., friend or relative):

LAST	FIRST	MIDDLE	RELATIONSHIP
STREET	APT		HOME PHONE: ( )
CITY	STATE	ZIP	BUSINESS DAYTIME PHONE: ( )

PHARMACY

Preferred Local Pharmacy	**Address**	**Phone number**
Alternate Local Pharmacy		
Mail Order Pharmacy		

PLEASE COMPLETE NEXT PAGE

FINANCIAL INFORMATION

PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMOs, POSs, PPOs), OR AUTHORIZATION TO BILL WORKERS' COMPENSATION OR OTHER THIRD PARTY PAYOR.

PRIMARY INSURANCE:

PRIMARY INSURANCE CARRIER NAME		POLICY #	GROUP #	COPAY	PLAN TYPE (HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY STATE ZIP		SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

SECONDARY INSURANCE:

PRIMARY INSURANCE CARRIER NAME		POLICY #	GROUP #	COPAY	PLAN TYPE (HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY STATE ZIP		SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

IS THIS VISIT DUE TO A WORK RELATED CONDITION? ☐ Yes ☐ No

WILL YOU BE USING WORKERS' COMPENSATION INSURANCE? ☐ Yes ☐ No

EMPLOYER		WORK COMP INSURANCE COMPANY NAME		ADJUSTOR NAME
STREET		STREET		DATE/DESCRIPTION OF INJURY
CITY STATE ZIP		CITY STATE ZIP		W/C POLICY NO.
PHONE TO VERIFY W/C ( )		W/C INSURANCE PHONE ( )		CLAIM NO.

1. FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by a Kelly Rich Family Medicine (KRFM) physician, unless the services are deemed "paid in full" as a result of a contractual agreement between the KRFM and my insurer.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize KRFM to release any medical, psychiatric, infectious diseases (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance heron.

3. CONSENT FOR OBTAINING PRESCRIBED MEDICAL HISTORY

I hereby authorize KRFM to obtain electronically or by other means all of my prescription history. I understand this is important to provide the best medical care.

4. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to KRFM, the surgical and/or medical benefits. If any, otherwise payable to me for their services as described on attached claim, but not to exceed the charges for those services. I understand I am financially responsible to the Center for charges not covered by this agreement.

5. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier 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 either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature_____Date:_____